

# COVID-19 Pandemic Guidance

for Health Care for the Homeless Programs  
and Homeless Services Providers



July 2022

Courtney Pladsen, DNP, FNP-BC  
Katie League, LCSW-C  
Kate Gleason-Bachman, RN, MPH

# Table of Contents

<b>Acknowledgments .....</b>	<b>4</b>
<b>Introduction .....</b>	<b>5</b>
COVID-19 Transmission .....	7
Racial Inequities .....	8
From the Field: Compounding Crises in San Jose, Calif. ....	11
Additional Resources: General Information on COVID-19 and Homeless Populations .....	11
<b>Decreasing Transmission of COVID-19 .....</b>	<b>14</b>
Vaccination .....	14
Masks .....	14
Physical Distancing .....	15
Personal Protective Equipment .....	15
Ventilation .....	16
Cleaning and Disinfection Measures .....	16
Additional Resources: Decreasing Transmission of COVID-19 .....	17
<b>Screening for COVID-19 and Follow-Up Planning .....</b>	<b>19</b>
Isolation .....	21
Quarantine .....	22
From the Field — Spring/Summer 2020: Medical Complexity During a Pandemic in Washington, D.C. ....	24
Medical Respite .....	25
Winter Considerations .....	28
From the Field — 2020: Alternate Care Sites in Santa Clara, Calif. ....	29
Additional Resources: Shelters, Medical Respite Care, Alternate Care Sites and I&Q Facilities	29
<b>Testing .....</b>	<b>32</b>
Contact Tracing .....	35
Additional Resources: Testing .....	36
<b>Providing Clinical Care During the COVID-19 Pandemic .....</b>	<b>37</b>
Caring for People With COVID-19 .....	37
Telehealth .....	42
Special Populations .....	43

From the Field: Fostering Mental Well-Being During a Pandemic in Tennessee.....	44
From the Field — 2020: When the Health Center Is Considered “Home” in San Jose, Calif....	45
Staff Burnout .....	46
Additional Resources: Telemedicine .....	46
<b>Substance Use, Harm Reduction and Treatment .....</b>	<b>48</b>
Risks of Substance Use During COVID-19 .....	49
Effects of COVID-19 on Caring for Individuals With Active Substance Use .....	49
Background on Harm Reduction .....	50
From the Field: Harm Reduction and MOUD During a State of Emergency in New York City .....	<b>Error! Bookmark not defined.</b>
Enhancing Care for Individuals With Active Substance Use During COVID-19 .....	50
From the Field: Harm Reduction and MOUD During a State of Emergency in New York City...	51
Reducing Overdose Risk .....	52
Syringe Exchange and Use Kits .....	53
SUD Care and Intervention in Shelter and Residential Settings .....	53
Substance Use Treatment .....	54
From the Field: The Value of Managed Alcohol Programs in San Francisco .....	58
Managed Alcohol Programs .....	59
Additional Resources: Behavioral Health/Harm Reduction .....	64
<b>COVID-19 Vaccination .....</b>	<b>65</b>
<b>Participation in Planning Efforts.....</b>	<b>72</b>
Additional Resources: Communitywide Response to COVID-19 .....	75
<b>Conclusion.....</b>	<b>76</b>
<b>Appendix 1: Screening Tools .....</b>	<b>77</b>
<b>Appendix 2: Staffing Models for Managed Alcohol Programs .....</b>	<b>82</b>
<b>Appendix 3: Sample Clinical Assessment Form.....</b>	<b>84</b>
<b>Appendix 4: Sample Intake Form .....</b>	<b>86</b>
<b>Appendix 5: Sample Clinical Care Record .....</b>	<b>87</b>
<b>Appendix 6: Sample Client Alcohol Management Plan and Agreement.....</b>	<b>89</b>

# Acknowledgments

A special thanks to the following colleagues who spent considerable time contributing to this document:

Alice Moughamian, RN, CNS  
Bobby Watts, MPH, MS, CPH  
Caitlin Synovec, OTD, OTR/L, BCMH  
Cindy Manginelli, BS  
D. Michael Durham, MTS  
Darlene Jenkins, DrPH  
Devora Keller, MD, MPH  
Hugo Aguas, MA  
Irene Guerra, PhD  
Jacqueline Newton, MD, MPH  
Jonathan Giftos, MD  
Kelli Klein, BA  
Lawrence Chang, PharmD, BCPS  
Lily Catalano, MSSW  
Mary Tornabene, MS, APRN, FNP-BC  
Nathan Furukawa, MD, MPH  
Regina Olatin, DO, FAAP, FACP  
Shannon Smith-Bernadin, PhD, RN, CNL

## Funding Disclaimer

This resource was developed with support from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to the National Health Care for the Homeless Council for \$1,967,147 with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more info visit [HRSA.gov](https://www.hrsa.gov)

# Introduction

On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic.<sup>1</sup> In the more than two years since this declaration, over 6 million people worldwide have died from COVID-19, including over 1 million people in the United States.<sup>2</sup> Older people and those with chronic medical conditions like cardiovascular disease, chronic respiratory illness and diabetes disproportionately experience morbidity and mortality related to COVID-19.<sup>3</sup> The burden of this illness has also disproportionately impacted Black, Indigenous, Latino and Hispanic communities in the U.S. due to social and health inequities. While vaccines have had a significant positive impact on the incidence of severe disease and mortality, there remains an ongoing need to promote vaccination, respond to new variants, address seasonal challenges and continue targeted prevention efforts for at-risk groups.

People experiencing homelessness are at an increased risk of severe illness from COVID-19 due to generally higher rates of chronic illnesses compared to the general population.<sup>4,5</sup> Exacerbated by staying in densely populated shelters or on the street, and by limited access to regular health care, these underlying conditions have created an ongoing challenge for people experiencing homelessness. This guide aims to gather the most up-to-date information and provide guidance to organizations and programs who serve people experiencing homelessness to minimize harm during the ongoing COVID-19 pandemic and moving forward. **This guide was last updated in July 2022 and will be updated biannually, as needed. Please note that cited resources contain publication dates where applicable and that many linked resources will take the reader to the most recently published document or guidelines.**

---

<sup>1</sup>Tedros, A. G. (2020, March 11). *WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020*. World Health Organization. <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>

<sup>2</sup> WHO Coronavirus (COVID-19) Dashboard. (n.d.). WHO. Retrieved July 5, 2022, from <https://covid19.who.int/>

<sup>3</sup> CDC. (2022a, May 2). *People with Certain Medical Conditions*. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>  
<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

<sup>4</sup> Baggett, T.P., Hwang, S.W., O'Connell, J.J., Porneala, B.C., Stringfellow, E.J., Orav, E.J., Singer, D.E., & Rigotti, N.A. (2013). Mortality among homeless adults in Boston. *JAMA Internal Medicine*, 173(3), 189-195.  
<https://doi.org/10.1001/jamainternmed.2013.1604>

<sup>5</sup> Henwood, B.F., Byrne, T., & Scriber, B. (2015). Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. *BMC Public Health*, 15(1). <http://doi.org/10.1186/s12889-015-2552-1>

**Graph 1: COVID-19 Symptoms<sup>8</sup>**

It is important to note that existing interventions around homelessness, in particular nonpermanent solutions and congregate shelters, have never been ideal and always presented a challenge with regards to infectious disease and safety. As the pandemic response shifts to an acknowledgement of the endemic nature of COVID-19, increased risks will remain for those experiencing homelessness. In responding to the pandemic, shelter and health care for the homeless providers should take into account federal, state and local guidance, as well as the unique needs of their communities, while also continuing to acknowledge that homelessness is unacceptable and working toward permanent housing solutions as our ultimate goal.

COVID-19 is caused by the SARS-CoV-2 virus, first discovered in Wuhan, China, in December 2019.<sup>6</sup> Since the first wave of the pandemic in late 2019 and early 2020, the world has experienced multiple waves of increased disease spread and multiple variants of the original virus. In spring 2022, the majority of severe disease, hospitalizations and deaths occurred in people who were not vaccinated against COVID-19.<sup>7</sup>

Symptoms of COVID-19 may appear two to 14 days after exposure. The symptoms of COVID-19 can vary widely or include no symptoms. Those who have symptoms often experience at least some of the following: fever, cough, shortness of breath, body aches, loss of smell/taste, headache, sore throat, congestion or runny nose, nausea/vomiting, and diarrhea.<sup>8</sup> The most common COVID-19 symptoms are listed in Graph 1, but this list is not

exhaustive. Anyone can experience mild to severe symptoms, but those who are unvaccinated, older and/or have underlying chronic medical conditions are at higher risk for severe disease.<sup>7</sup>

<sup>6</sup> CDC. (2022, March 11). *Frequently Asked Questions*. <https://www.cdc.gov/coronavirus/2019-ncov/faq.html>

<sup>7</sup> CDC. (n.d.-b). *COVID Data Tracker: Rates of COVID-19 Cases and Deaths by Vaccination Status*. Retrieved July 7, 2022, from <https://covid.cdc.gov/covid-data-tracker/#datatracker-home>

<sup>8</sup> CDC. (2022b, March 22). *Symptoms of COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

## COVID-19 Transmission

COVID-19 spreads primarily through droplet or airborne transmission. Transmission is most likely to occur in enclosed indoor spaces, areas of inadequate ventilation and with prolonged exposure to respiratory particles.<sup>9</sup> The most recent variant of note, omicron, is more easily transmitted than previous versions of the virus and can spread quickly in indoor spaces.<sup>10</sup> Droplets or aerosols are released when someone with COVID-19 coughs, talks or sneezes.<sup>11</sup> Infectious droplets or particles can then land in the mouths or noses of people nearby or, possibly, be inhaled into the lungs. Though much less common, transmission of COVID-19 is also possible by touching a surface or object that has the virus on it and then touching the mouth, nose or eyes.<sup>10</sup>

It is important to recognize asymptomatic, pre-symptomatic and symptomatic as distinct types or phases of COVID-19 infections. Asymptomatic cases occur when individuals have COVID-19 infection and do not experience any symptoms of the illness. Despite the lack of symptoms, they remain contagious and may pass the infection on to others. Vaccinated individuals can also spread COVID-19 through asymptomatic infections.<sup>12</sup>

Pre-symptomatic refers to the period when a person has been infected but is not yet experiencing symptoms. Among those who eventually develop symptomatic infection, SARS-CoV-2 viral load peaks shortly before symptom onset, and the risk of transmission is highest a few days before and after symptom onset. A Centers for Disease Control and Prevention analysis in 2021 suggests more than half of transmissions occur from people without symptoms (35% pre-symptomatic, 24% asymptomatic, 41% symptomatic).<sup>13</sup> The time between becoming infected and symptom onset varies based on the COVID variant but is, on average, five to six days, though it can be up to 14 days.<sup>14</sup>

The high rates of asymptomatic and pre-symptomatic spread of the infection underscore the importance of prevention measures, including vaccination, masks, physical distancing and hand-

---

<sup>9</sup> CDC. (2021a, July 14). *How COVID-19 Spreads*. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>

<sup>10</sup> CDC. (2022c, March 29). *Omicron Variant: What You Need to Know*. <https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html>

<sup>11</sup> CDC. (2021b, December 6). *Transmission*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/overview/index.html#transmission>

<sup>12</sup> CDC. (2022d, June 23). *COVID-19 after Vaccination: Possible Breakthrough Infection*. <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html>

<sup>13</sup> Johansson, M. A., Quandelacy, T. M., Kada, S., Prasad, P. V., Steele, M., Brooks, J. T., Slayton, R. B., Biggerstaff, M., & Butler, J. C. (2021). SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. *JAMA Network Open*, 4(1). <https://doi.org/10.1001/jamanetworkopen.2020.35057>

<sup>14</sup> CDC. (2022b, March 22). *Symptoms of COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>



washing. Understanding symptoms and transmission patterns is imperative to keep communities safe while providing much-needed resources like shelter, health care and food services.

## Racial Inequities

The pandemic has highlighted and exacerbated inequities in the United States. Many who were struggling and on the margins pre-pandemic have experienced compounding crises. The pandemic has highlighted inequities that impact both general health status and outcomes of COVID-19 infection.<sup>15</sup> Black, Latino/Hispanic and Indigenous communities have experienced a disproportionate number of deaths due to COVID-19, beginning early in the pandemic. Poverty, available community resources, occupation and health access can impact overall health and COVID-19 risk, and marginalized communities are disproportionately impacted by inequity in these areas.<sup>16</sup> In addition to fighting inequities in health care, housing and other resources, it is also imperative to work for equity in vaccine access for marginalized groups, including people experiencing homelessness.

Health systems have a long history of discrimination in the United States. This history includes involuntary medical experimentation on Black, Indigenous and people of color communities (BIPOC), segregated medical facilities, lack of access to treatment and high barriers to accessing medical education.<sup>17</sup> Systemic racism drives social and economic factors that can lead to chronic and toxic stress.<sup>18</sup> These factors contribute to BIPOC having higher rates of chronic illnesses like diabetes, hypertension, heart disease and asthma.<sup>19,20</sup> Racial and ethnic inequities in health care persist even when insurance status, income, age and severity of illness are the same.<sup>21</sup> It is *racism* — not *race* — that causes inequities in health outcomes; race is not a social determinant of health, racism is.<sup>22</sup> Due to the pervasive inequities that communities of color face both

---

<sup>15</sup> CDC. (n.d.-b). *What is Health Equity?* Retrieved July 7, 2022, from <https://www.cdc.gov/healthequity/whatis/>

<sup>16</sup> CDC. (2020, December 10). *Disparities in Deaths from COVID-19: Racial and Ethnic Health Disparities*. CDC via Internet Archive. Retrieved July 7, 2022, from <https://web.archive.org/web/20220602202248/https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-deaths.html>

<sup>17</sup> Nuriddin, A., Mooney, G., & White, A. I. R. (2020). Reckoning with histories of medical racism and violence in the USA. *The Lancet*, 396(10256), 949–951. [https://doi.org/10.1016/s0140-6736\(20\)32032-8](https://doi.org/10.1016/s0140-6736(20)32032-8)

<sup>18</sup> Barnhouse, M., & Jones, B. L. (2019). The Impact of Environmental Chronic and Toxic Stress on Asthma. *Clinical Reviews in Allergy & Immunology*, 57(3), 427–438. <https://doi.org/10.1007/s12016-019-08736-x>

<sup>19</sup> Nelson, A. (2002a). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, 94(8), 666. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/>

<sup>20</sup> Yearby, R. (2018). Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism. *American Journal of Economics and Sociology*, 77(3–4), 1113–1152. <https://doi.org/10.1111/ajes.12230>

<sup>21</sup> Nelson, A. (2002b). Unequal treatment: confronting racial and ethnic disparities in health care. *Journal of the National Medical Association*, 94(8), 666. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594273/>

<sup>22</sup> Phelan, J. C., & Link, B. G. (2015). Is Racism a Fundamental Cause of Inequalities in Health? *Annual Review of Sociology*, 41(1), 311–330. <https://doi.org/10.1146/annurev-soc-073014-112305>.



historically and currently, high rates of transmission have led to a disproportionate rate of mortality and morbidity of COVID-19 among these communities.<sup>23</sup> Inequities have persisted among communities of color, both in terms of morbidity and mortality but also in vaccine and booster dose uptake.<sup>24</sup>

People experiencing homelessness have higher rates of illness and die earlier than their housed counterparts. Statistics vary by jurisdiction, but regions that have analyzed age at death show the average age at death for people experiencing homelessness to be between 48 and 52.<sup>25,26</sup> That is almost 30 years sooner than the U.S. general population.<sup>27</sup> Even before the COVID-19 pandemic, congregate settings like homeless shelters exposed individuals to communicable diseases such as tuberculosis, pneumonia, flu, hepatitis, et al. Housing instability (including couch-surfing, known as doubling-up) makes it difficult to adhere to COVID-19 prevention measures such as physical distancing.

A 2022 analysis by the Kaiser Family Foundation that included the omicron surge found that Black, Latino/Hispanic and Indigenous people experienced higher rates of infection and death when compared to white people throughout the pandemic, when accounting for age at illness and/or death. Their analysis also found that these disparities tended to become larger during surges in virus activity, such as those related to the delta and omicron variants.<sup>28</sup>

Despite Black individuals accounting for 13% of the general population, they account for 40% of the entire homeless population nationally.<sup>29</sup> The intersections between race, socioeconomic status and lack of housing demonstrate the structural inequities in our society that compound

---

<sup>23</sup> Wilder, J. M. (2020). The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. *Clinical Infectious Diseases*, 72(4), 707–709. <https://doi.org/10.1093/cid/ciaa959>

<sup>24</sup> CDC. (n.d.-a). *COVID Data Tracker: Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States*. Retrieved July 7, 2022, from <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic>.

<sup>25</sup> Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B. C., Stringfellow, E. J., Orav, E. J., Singer, D. E., & Rigotti, N. A. (2013b). Mortality Among Homeless Adults in Boston. *JAMA Internal Medicine*, 173(3), 189. <https://doi.org/10.1001/jamainternmed.2013.1604>

<sup>26</sup> Roy, A., & Rosenstock, C. (2021). *We Do Not Forget: Stolen Lives of LA's Unhoused During the COVID-19 Pandemic*. UCLA Luskin Institute on Inequality and Democracy. <https://escholarship.org/uc/item/9104j943>

<sup>27</sup> Murphy, S. L., Kochanek, K. D., Xu, J. Q., & Arias, E. (2021). Mortality in the United States, 2020. *NCHS Data Brief*, 427. <https://doi.org/10.15620/cdc:112079>

<sup>28</sup> Hill, L., & Artiga, S. (2022, February 22). *COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time*. KFF. <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/>

<sup>29</sup> *Homelessness and Racial Disparities*. (2020, October). National Alliance to End Homelessness. <https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/inequality/>

negative effects and have led to high susceptibility to COVID-19 infections, more severe disease and higher risk for death.<sup>30, 31</sup>

Inequalities have also been evident in lower vaccine and booster dose uptake and among historically marginalized groups.<sup>24</sup> When developing plans for vaccine education and vaccination, it is important to understand the history of racism and how roots of mistrust were sown many years ago and persist today. The exploitation and marginalization of BIPOC cannot be overlooked in understanding health disparities today. Building and earning trust and dismantling racism in health care will require fundamental policy and system changes. The HCH community must work to develop trust with their communities as a step toward cultivating an antiracist movement and decreasing inequalities.

Throughout this manual, we encourage an equity lens, as opposed to a “colorblind” approach. An equity lens recognizes the historical and contemporary systems that lead to better access for some at the expense of others and actively subverts those systems. This is essential to offset the structural and systemic inequities that exist. People with the lived experience of homelessness are a central part of all community and organizational design planning and must be included in all conversations about the pandemic disaster response. People closest to the problems are closest to the solutions.

---

<sup>30</sup> Killerby, M. E., Link-Gelles, R., Haight, S. C., Schrodtt, C. A., England, L., Gomes, D. J., Shamout, M., Pettrone, K., O’Laughlin, K., Kimball, A., Blau, E. F., Burnett, E., Ladva, C. N., Szablewski, C. M., Tobin-D’Angelo, M., Oosmanally, N., Drenzek, C., Murphy, D. J., Blum, J. M., . . . Wong, K. K. (2020). Characteristics Associated with Hospitalization Among Patients with COVID-19 — Metropolitan Atlanta, Georgia, March–April 2020. *MMWR. Morbidity and Mortality Weekly Report*, 69(25), 790. <https://doi.org/10.15585/mmwr.mm6925e1>

<sup>31</sup> Stokes, E. K., Zambrano, L. D., Anderson, K. N., Marder, E. P., Raz, K. M., el Burai Felix, S., Tie, Y., & Fullerton, K. E. (2020). Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020. *MMWR. Morbidity and Mortality Weekly Report*, 69(24), 759. <https://doi.org/10.15585/mmwr.mm6924e2>

## From the Field: Compounding Crises in San Jose, Calif.

Irene Guerra, PhD, a psychologist at Santa Clara Valley Medical Center (SCVMC), shared that, in 2020, migrant farmworkers faced extreme barriers to care and were particularly vulnerable during the pandemic. The SCVMC operates Centro De Salud Movil Saludos/Saludos Mobile Health Center, a mobile health program that provides essential health care and connects to resources like psychoeducation, nutrition, state disability application assistance and legal aid. Due to safety measures, these vital resources were not available early in the pandemic. Farmworkers lacked proper personal protective equipment during the early pandemic while they worked to maintain the U.S. food supply, which is especially concerning given that California's wildfires produced extremely poor air quality, increasing respiratory risk. These farm workers had no access to videoconferencing for telehealth and had limited phone resources, precluding them from behavioral health services, which led to very low participation rates and a significant decrease in referrals. Staff reported a significant increase in depression, in part due to the social isolation and difficulty connecting with families abroad. At one point, the clinical sites had to close due to poor air quality, despite the farmers' work remaining unchanged. This was heartbreaking for staff and contributed to moral injury.

## Additional Resources: General Information on COVID-19 and Homeless Populations

### *Guidance From the National Health Care for the Homeless Council*

- [Issue Brief: COVID-19 & the HCH Community: Further Illustrating the Benefits of "Medicare-for-All"](#) (July 2020)
- [Webinar: COVID-19 Coffee Chat: Continuity of Care for Residents in Permanent Supportive Housing](#) (May 2020)
- [COVID-19 Data Dashboard: Health Care for the Homeless Comparative Data](#)
- [Issue Brief: COVID-19 & the HCH Community: Needed Actions from Public Health and Emergency Response Systems](#) (April 2020)
- [Things to Do During the COVID-19 Crisis If You Have Diabetes](#) (March 2020)

### *Guidance From Federal Agencies*

- [Interim Guidance for Homeless Service Providers to Plan and Respond to COVID-19](#) (CDC, February 2022)

- [Homelessness and COVID-19 FAQs](#) (CDC, February 2021)
- [Help Stop the Spread of COVID-19 by Watching for These Possible Symptoms / Spanish-Language Version](#) (HUD)
- Homeless Populations: Resources to Support People Experiencing Homelessness (February 2022)
- [How COVID Spreads](#) (CDC, July 2021)
- [Coronavirus \(COVID-19\) Frequently Asked Questions](#) (Health Resources and Services Administration)
- [Emergency Preparedness and Recovery Resources for Health Centers](#) (HRSA, January 2022)
- [Coronavirus Resources](#) (Assistant Secretary for Preparedness and Response, HHS)

### ***Guidance From National Organizations***

- [Resources for Care Coordination and Supportive Housing](#) (CSH, October 2021)

### ***Guidance on Equity***

- [On the Frontlines: Nonprofits Led by People of Color Confront COVID-19 and Structural Racism](#) (Building Movement Project, October 2020)
- [Staff Orientation to Racial Equity](#) (HUD, September 2020)
- [Creating a Cultural Equity Plan: Organizational Policies and Procedures](#) (HUD, September 2020)
- [Equity Capacity Building: Hiring, Supervision, Training](#) (HUD, August 2020)
- [Racial Trauma and Trauma-Informed Services](#) (HUD, August 2020)
- [Integrating Equity in the Time of COVID-19](#) (Homebase, July 2020)
- [Race, Homelessness, and COVID-19: Guidance for Homeless Services Providers](#) (Coalition on Homelessness and Housing in Ohio, April 2020)
- [COVID-19 Racial Equity Resource Guide](#) (Los Angeles Homeless Services Authority, May 2020)
- [Prevention to Promote Equity](#) (HUD, June 2020)
- [Webinar: "Policing, Incarceration, & COVID-19"](#) (National Homelessness Law Center, June 2020)
- [Webinar: "Compounding Oppression: Antiracism in COVID-19 Response"](#) (NHCHC, May 2020)
- ["Racial Justice During Crises: COVID Will Show You Whether It's a Priority,"](#) (NHCHC, May 2020)
- [COVID-19 — Racial Equity and Social Justice Resources](#) (Racial Equity Tools, 2020)
- [Reducing Stigma](#) (CDC, July 2021)

- [Equity Tool](#) (Corporation for Supportive Housing, 2022)
- [Centering Equity in Health and Housing Partnerships in Times of Crisis and Beyond](#) (CSH, August 2020)
- [Crises as Catalyst: A Call for Race Equity & Inclusive Leadership](#) (ProInspire, 2020)

# Decreasing Transmission of COVID-19

## Key Recommendations:

- Vaccination is our best prevention tool.
- Universal masking during times of high virus activity.
- Follow federal, state and local guidance; increase precautions beyond guidance if warranted for your community.

## Vaccination

Vaccination of all eligible people aged 6 months and above, including recommended booster shots, is the best prevention measure against the spread of coronavirus. Vaccines prevent illness and disease spread and allow services for people experiencing homelessness to continue with the least possible disruption.<sup>32</sup> See the below section for more details on vaccination guidelines and strategies to increase vaccinations rates among people experiencing homelessness.

## Masks

Masks remain an important prevention measure in shelters and other congregate settings. While mask mandates and masking recommendations have changed with the emergence of new waves and variants, universal masking remains recommended by the CDC in shelters and congregate settings, regardless of vaccination and booster status.<sup>33</sup> Masks should fit properly (with no gaps) and completely cover the mouth and nose. While the most important thing is to have a well-fitting mask that is comfortable to wear properly, there are some masks that offer better protection than others. A procedure mask offers better protection than a cloth mask, and respirators (N95, KN95) offer the best protection. Cloth masks are not recommended for congregate settings. Service providers should model proper mask-wearing and remind clients and colleagues about mask-wearing when needed.

---

<sup>32</sup> *How to Protect Yourself and Others*. (2022, February 25). CDC. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>

<sup>33</sup> *Interim Guidance for Homeless Service Providers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)*. (2022, February 10). CDC. <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>

## Physical Distancing

Physical distancing, often called social distancing, remains a strategy to decrease virus transmission in shelter and congregate settings. The CDC recommends maintaining a distance of at least 6 feet during meals or having people eat in their rooms, if possible. The CDC also recommends sleeping arrangements that avoid people's heads being within 6 feet of each other, e.g., increasing space between beds and/or using a head-to-toe model for beds that are in closer proximity.<sup>34</sup> Service providers can encourage physical distancing by posting signs as reminders to maintain distance and placing visual markers 6 feet apart. Physical distancing can be easier in outdoor settings; with good air circulation, the risk of transmission outdoors is lower than in indoor settings.

## Personal Protective Equipment

PPE is special clothing and equipment designed to create a barrier against health and safety hazards. Examples of PPE include goggles, face shields, gloves and respirators; cloth face coverings are not PPE. Health centers should maintain adequate PPE supplies for staff. When caring for someone who is suspected of having or has been confirmed to have COVID-19, clinical staff ought to have the following PPE:<sup>35</sup>

- Face shield or goggles
- N95 mask (respirator)
- Clean, nonsterile gloves
- Isolation gown

In the event of a shortage of PPE, several steps can be taken to help optimize the supply:<sup>36</sup>

- Use physical barriers and other engineering controls.
- Limit the number of patients in the clinic setting.
- Use telemedicine whenever possible.
- Limit all health care professionals not directly involved in patient care.
- Limit face-to-face encounters with patients.

---

<sup>34</sup> Interim Guidance for Homeless Service Providers to Plan and Respond to Coronavirus Disease 2019 (COVID-19). (2022, February 10). CDC. <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>

<sup>35</sup> CDC. (n.d.-d). *Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19* [Poster]. [https://www.cdc.gov/coronavirus/2019-ncov/downloads/A\\_FS\\_HCP\\_COVID19\\_PPE.pdf](https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf)

<sup>36</sup> CDC. (2020b, December 29). *Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html>



- Cohort patients upon screening into the program (i.e., symptomatic and asymptomatic).
- Routine surveillance testing for all staff and clients/patients.

The [CDC's Personal Protective Equipment \(PPE\) Burn Rate Calculator](#) can help calculate the amount of PPE a program has and optimize its PPE supply. This tool can be used in clinical and nonclinical programs to help prevent a PPE shortage. During surges of community spread of COVID-19, PPE supplies may be locally strained, and programs need to balance caring for community members and protecting their staff. The CDC recommends stages of capacity (conventional, contingency, and crisis) and adjusting programs depending on the level of PPE on hand.<sup>37</sup>

**Examples of frequently touched surfaces and objects that will need routine disinfection:**

- Tables
- Doorknobs
- Light switches
- Countertops
- Handles
- Desks
- Phones
- Keyboards
- Toilets
- Faucets and sinks
- Touch screens

## Ventilation

Because COVID-19 is primarily spread through droplets and airborne particles, adequate ventilation and air filtration are important prevention measures. Facilities should ensure that ventilation systems are operating optimally and should consider the following:<sup>38</sup>

- Increase the delivery of outdoor air into the building or ventilation systems as much as possible. This could mean opening windows, if safe, or setting ventilation systems to intake as much as possible from outdoor air.
- Ensure exhaust fans in kitchens and restrooms operate at full capacity; consider running these fans for several hours after the building is occupied, if possible and applicable.
- Consider the use of high-efficiency particulate air fan/filtration systems, especially in areas where people will be eating or sleeping or where symptoms screening is occurring.
- Consider ultraviolet germicidal irradiation systems to supplement the use of HEPA filters.

## Cleaning and Disinfection Measures

While not a primary mode of transmission, coronaviruses can be spread by touching contaminated surfaces and then touching the eyes, nose or mouth. Frequent and routine

<sup>37</sup> CDC. (2020c, July 16). *Optimizing Supply of PPE and Other Equipment During Shortages*.

[www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html)

<sup>38</sup> CDC (2021c, June 2). Ventilation in Buildings. [www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html](https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html)

disinfection of surfaces and objects that have been touched by multiple people is important to reduce the risk of virus transmission. When disinfectants approved by the Environmental Protection Agency are not available, alternative disinfectants can be used (for example, one-third cup of 5.25% to 8.25% bleach added to 1 gallon of water, or 70% alcohol solutions).<sup>39</sup> Bleach solutions will be effective for disinfection up to 24 hours.

### *Hand-Washing and Hand Sanitizer*

Washing hands with soap and water is preferable to using hand sanitizer whenever possible, as it decreases amounts of all types of germs and chemicals on hands.<sup>40</sup> When soap and water are not available, use a hand sanitizer with at least 60% alcohol. Hand sanitizer can reduce the number of microbes on the hands but does not eliminate them. Many studies have found that sanitizers with an alcohol concentration between 60% to 95% are more effective at killing germs than those with a lower alcohol concentration or non-alcohol-based hand sanitizers.<sup>41, 42</sup>

## **Additional Resources: Decreasing Transmission of COVID-19**

### *Guidance From the National Health Care for the Homeless Council*

- [Quick Information: How to Use Personal Protective Equipment: A Quick Reference Guide for Frontline Clinical Providers](#) (April 2020)

### *Guidance From Federal Agencies*

- [Updated Guidance for Shelters and Congregate Settings](#) (CDC, February 2022)
- [Guidance on Masking](#) (CDC, January 2022)
- [Preventing and Managing the Spread of Infectious Disease for People Experiencing Homelessness](#) (HUD, March 2020)
- [Guidance for People Experiencing Unsheltered Homelessness](#) (CDC, February 2022)
- [Strategies for Optimizing the Supply of PPE](#) (CDC, July 2020)
- [Ventilation in Buildings](#) (CDC, June 2021)
- [New Integrated Approaches to Minimize the COVID-19 Risk and Address Rehousing Needs](#) (HUD, 2020)

---

<sup>39</sup> CDC. (2021b, November 15). *Cleaning and Disinfecting Your Facility: Every Day and When Someone Is Sick*. <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

<sup>40</sup> CDC. (n.d.-e). *Show Me the Science – When & How to Use Hand Sanitizer in Community Settings*. <https://www.cdc.gov/handwashing/show-me-the-science-hand-sanitizer.html>

<sup>41</sup> Todd, E. C. D., Michaels, B. S., Holah, J., Smith, D., Greig, J. D., & Bartleson, C. A. (2010). Outbreaks Where Food Workers Have Been Implicated in the Spread of Foodborne Disease. Part 10. Alcohol-Based Antiseptics for Hand Disinfection and a Comparison of Their Effectiveness with Soaps. *Journal of Food Protection*, 73(11), 2128–2140. <https://doi.org/10.4315/0362-028x-73.11.2128>

<sup>42</sup> Kampf, G., & Kramer, A. (2004). Epidemiologic Background of Hand Hygiene and Evaluation of the Most Important Agents for Scrubs and Rubs. *Clinical Microbiology Reviews*, 17(4), 863–893. <https://doi.org/10.1128/cmr.17.4.863-893.2004>

- [COVID-19 Infection Control Inventory and Planning \(ICIP\) Tool for Homeless Service Providers](#) (CDC, June 2020)
- [6 Steps for Safe & Effective Disinfectant Use](#) (EPA, April 2020)

# Screening for COVID-19 and Follow-Up Planning

## Key Recommendations:

- Screening should be done prior to entry into a program setting like a health center, shelter or soup kitchen.
- Screening is only one part of a comprehensive strategy to decrease transmission of COVID-19 and should not prevent someone from obtaining needed shelter.
- Isolation and quarantine sites need to be identified for people who are experiencing homelessness and screen positive for symptoms, test positive or who have had a known exposure.

Screening for COVID-19 symptoms is one part of a comprehensive plan for reducing transmission. The most current data show that 40% of infections are asymptomatic; screening alone is insufficient for detecting COVID-19 infections.<sup>43</sup> Each community's strategic plan should include a process for screening, isolation, quarantining, testing and supporting individuals who are suspected to have or who have tested positive for COVID-19. Housing and health care settings have traditionally been siloed. This is an opportunity for organizations, public health departments and health systems to partner and create a continuum of housing and care for people who are experiencing homelessness. These interagency partnerships can be leveraged in the future to develop innovative health care delivery models.

**Table 1: COVID-19 Screening**

COVID-19 Screening Questions <sup>44</sup>	
1. <b>Determine whether the client has a fever by:</b>	<ul style="list-style-type: none"> <li>○ Taking their temperature using a temporal thermometer and/or</li> <li>○ Asking, <b>"Have you felt like you had a fever in the past two days?"</b></li> </ul>

<sup>43</sup> Ma, Q., Liu, J., Liu, Q., Kang, L., Liu, R., Jing, W., Wu, Y., & Liu, M. (2021). Global Percentage of Asymptomatic SARS-CoV-2 Infections Among the Tested Population and Individuals With Confirmed COVID-19 Diagnosis. *JAMA Network Open*, 4(12). <https://doi.org/10.1001/jamanetworkopen.2021.37257>

<sup>44</sup> CDC. (2020a, August 3). *Screening Clients for COVID-19 at Homeless Shelters or Encampments*. <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/screening-clients-respiratory-infection-symptoms.html>

2. **Ask the client, “Do you have a new or worsening cough today?”**

3. **Ask the client, “Do you have any of these other symptoms?”**

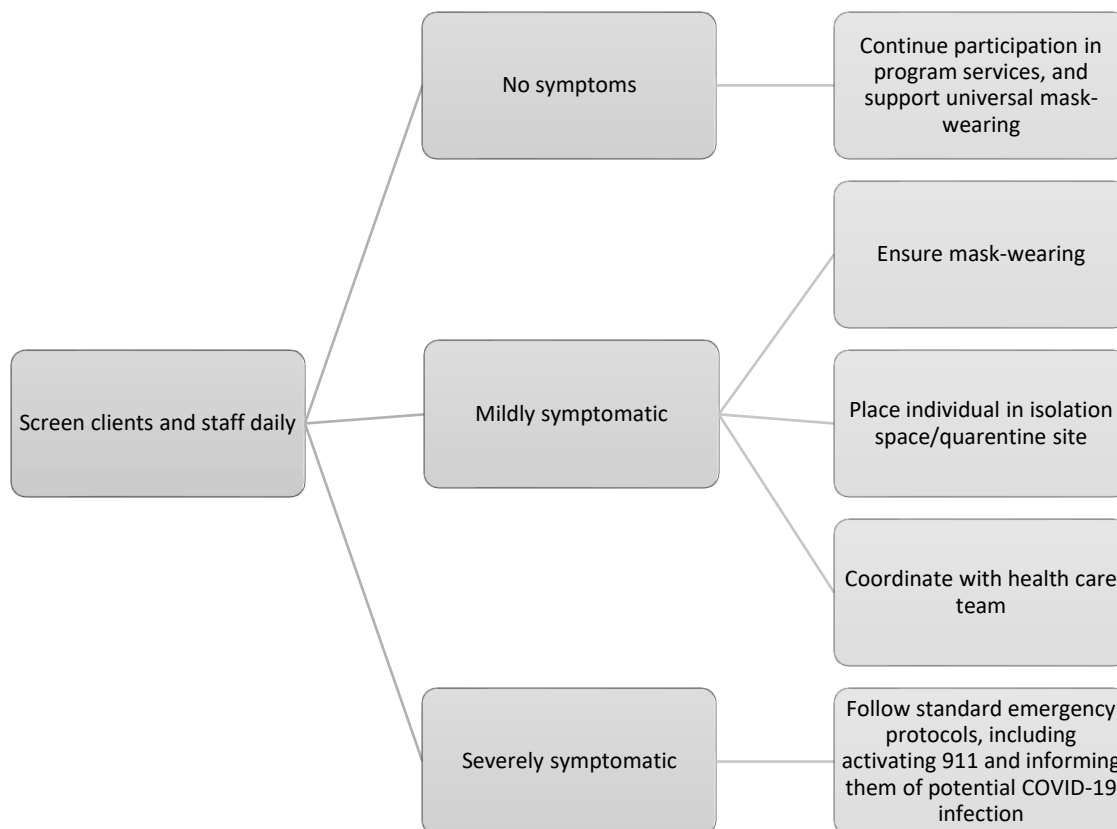
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

If the client has a fever **OR** a new/worsening cough **OR** any of the other symptoms:

1. **Provide a [mask](#) for the client to wear over their nose and mouth.** If the location is considered a health care setting, the client will be expected to wear the mask at all times except when eating or sleeping. Masks continue to be recommended in any congregate setting where person-to-person transmission is likely to occur. Masking requirements will change in communities as community COVID-19 rates fluctuate; however, they will always remain an effective way to decrease transmission of any airborne illness, including COVID-19. If a mask is not available, advise the client about [cough etiquette](#) and provide tissues. Masks should not be placed on children younger than 2 years old, anyone who has trouble breathing or is unconscious, or anyone who is incapacitated or otherwise unable to remove the mask without assistance. Mask should not be worn while sleeping.
2. **Notify management and appropriate health care providers, per established protocols.**
3. **Direct the client to an isolation room, if available, or to the area designated for people with symptoms of COVID-19.** If your shelter does not have an area for people with symptoms, redirect the person to the location pre-specified by your CoC, public health department or community leadership. If none of these resources are available, advise client to socially distance and remain masked.
4. **Let the client know:**
  - If their symptoms worsen or they have trouble breathing, they should notify a member of the clinic or homeless shelter staff immediately.
  - In a congregate setting, they should not leave their room/the designated area except to use the restroom, and they should stay at least 6 feet away from others.
  - If they leave their room/the designated area, they must wear a mask.
  - They should [wash their hands](#) often or use a hand sanitizer that contains at least 60% alcohol.

During the winter months where cold and flu season are also present, it may be challenging to distinguish COVID-19 symptoms from other illnesses. While the loss of/change in smell and taste are unique symptoms of COVID-19, COVID-19 also shares symptoms with many other viral illnesses. The above procedures should be followed until a test confirms a diagnosis.

*Graph 2: Screening Algorithm*



## Isolation

Isolation refers to separating someone with suspected or confirmed COVID-19 from others to prevent person-to-person transmission. It is important to remember that people can transmit the disease to others before they demonstrate signs of being sick, as well as if they never develop symptoms. The [most current CDC guidance](#) (March 2022) advises that people who test positive for COVID-19 but remain asymptomatic should still isolate for five days. However, those who are residing in a congregate setting are recommended to isolate for 10 days after the date of their first positive RT-PCR test.<sup>45</sup> This guidance does allow for a shorter isolation period if the full 10 days is not possible due to staffing or resource shortages. Individuals with symptoms or test-confirmed COVID-19 should stay in isolation for at least five days after the first positive COVID-19 test.

<sup>45</sup> CDC. (2022a, January 14). *Ending Isolation and Precautions for People with COVID-19: Interim Guidance*. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

After the first five days, a person can end isolation if:

- Symptoms have improved.
- At least 24 hours have passed with no fever and without the use of fever-reducing medicine such as ibuprofen or acetaminophen.

If isolation is ended after five days, people should wear a well-fitted mask through day 10 any time they are around others.

Individuals with severe disease or who are immunocompromised should isolate for at least 10 days and should consult their doctor before ending isolation.

## Quarantine

Quarantine refers to separating someone who had close contact with another person who has COVID-19. During quarantine, it is possible that the exposed person never becomes infected or develops symptoms of COVID-19. However, due to high rates of asymptomatic illness, the recommendation is to remain in quarantine. This step is essential to slow or stop community spread of the virus. Individuals may be contacted by their local health department during contact tracing, and it may be recommended that they quarantine.

Quarantine guidance is based on a person's vaccination status. If a person was exposed to COVID-19 and is [up to date](#) on their COVID-19 vaccines, they do not need to quarantine unless they develop symptoms. Even if a person never develops symptoms, they should get tested at least five days after their last-known contact with someone who has COVID-19. They should watch for symptoms until day 10 and, if they develop symptoms, they should isolate immediately and get tested.

A person who is not up to date on their COVID-19 vaccines should quarantine for at least five days and get tested at least five days after exposure. Individuals residing in congregate settings should quarantine for 10 days unless not possible due to staffing or resource limitations. They should watch for symptoms until day 10 and, if they develop symptoms, they should isolate immediately and get tested.

An exposed person, regardless of vaccination status, should wear a well-fitted mask, regardless of local masking requirements, through day 10.

A close contact is defined by being within 6 feet of someone with COVID-19 for more than 15 minutes in a 24-hour period. Quarantine is not required for a close contact of a known case



when they have tested positive for COVID-19 within 90 days of the test date — unless they develop new or worsening symptoms.<sup>46</sup>

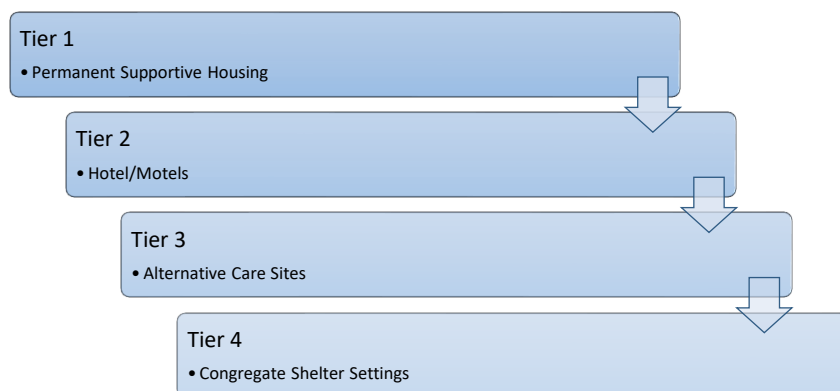
## Alternative Care Sites

Additional housing and shelter sites are necessary to depopulate congregate settings, support safe isolation for individuals who are symptomatic and awaiting testing/results or who have tested positive, and accommodate quarantine for those who have been exposed to COVID-19. These resources fall into a broad category called alternative care sites (ACS). Communities should plan four different settings for people who are experiencing homelessness depending on their status: 1. Screened with no symptoms. 2. Screened, have symptoms and awaiting testing/results. 3. Tested positive for COVID-19 and need to isolate. 4. Known contact with COVID-19-positive person but no current symptoms.

Due to shared bathrooms and sleeping quarters, congregate settings such as shelters are inherently challenging, even with physical distancing, universal mask-wearing and proper disinfection. This reinforces the key premise that **Housing is Health Care** and that homeless shelters were always an inadequate response to homelessness. Communities are encouraged to leverage partnerships and funding to develop new permanent supportive housing. Secure housing affords individuals much-needed stability for their mental and physical well-being. Absent enough permanent housing for everyone, a tiered approach may be necessary. Regardless of where people are sleeping, it is imperative that supportive services extend to these sites to retain a safety net of medical and/or social service staff.

### Graph 3: Tiered Housing Approach

Example of a tiered housing approach:



<sup>46</sup> CDC. (2022e, March 30). *Quarantine and Isolation*. <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html>

Hotels/motels have been utilized across the country to depopulate congregate shelter settings. They allow for single-room occupancy and eliminate shared bathrooms, both of which are helpful in decreasing transmission of COVID-19. A mixed-methods study conducted by Cook County in Washington state and the University of Washington explained that moving over 700 people out of congregate-shelter settings into hotels/motels successfully limited the spread of COVID-19.<sup>47</sup> The study revealed that, in addition to decreasing the transmission risk, this model had additional benefits, including:

- Increased feelings of stability associated with access to a consistent and private room.
- Improved health and well-being as indicated by improved sleep, hygiene and mental health through access to a clean and private room with bathroom facilities.
- Improved privacy and lessened anxiety that led to reduced interpersonal conflict, as evidenced by a decrease in emergency 911 call volume from hotel shelters.
- More time to think about and take steps toward future goals, such as securing permanent housing, a job or additional education.
- Higher exits to permanent housing and indications of greater engagement with housing services.

## **From the Field: Medical Complexity During a Pandemic in Washington, D.C.**

Dr. Catherine Crosland is the medical director of emergency response sites at Unity Health Care. Each year, Unity Health Care serves over 10,000 people experiencing homelessness in a variety of settings. Crosland helped to lead the effort caring for the nearly 800 individuals in quarantine and isolation hotel rooms. During the initial surge in Washington, D.C., there were over 60 admissions per day to these sites. What struck Crosland was the age and medical complexity of those being admitted to the alternative care sites. She reported that over 10% of the population had HIV and 15 individuals had end-stage renal disease requiring dialysis. There were individuals who had been diagnosed with cancer and were receiving chemotherapy, and there were three individuals older than 80. Before the pandemic, these individuals were sleeping in shelters or on the streets. Additionally, 84% of those in the ACS were Black or African American even though they represent only 49% of D.C.'s general population. Crosland shared that racial injustices and health inequities have been highlighted by the pandemic and that people who are experiencing homelessness are bearing the compounding effects.

---

<sup>47</sup> Colburn, G., Fyall, R., McHugh, C., Moraras, P., Ewing, V., Thompson, S., Dean, T., & Argodale, S. (2022). Hotels as Noncongregate Emergency Shelters: An Analysis of Investments in Hotels as Emergency Shelter in King County, Washington During the COVID-19 Pandemic. *Housing Policy Debate*, 1-23. <https://doi.org/10.1080/10511482.2022.2075027>

The potential downsides of the hotel/motel model include the lack of social connection, risk of overdose and the decompensation of mental or physical health. While the risk of COVID-19 transmission declines in this model, it is essential to develop contingency plans to prevent unintended consequences, as well as to outline harm-reduction interventions for those who are not able to isolate (see section on harm reduction below).

ACS were rapidly developed in communities during a surge of COVID-19 infections and can function as nontraditional health care settings for people who are symptomatic and awaiting test results, as well as people who are acutely ill but do not need hospital-level care.<sup>48</sup> While unbeknownst to many communities who developed them, ACS resemble an existing model of care called [medical respite](#).

## Medical Respite

Otherwise known as recuperative care, medical respite is acute and post-acute care to individuals who are experiencing homelessness who are too ill or frail to recover on the street or in a shelter but do not require hospital-level care.<sup>49</sup> As of January 2022, 133 medical respite programs exist nationwide, with many more in development. Many of these programs rapidly expanded during the pandemic and have served as models of ACS. Hotels/motels that serve as ACS for people who are ill require some level of systematic medical monitoring through outreach teams and/or telehealth. Refer to the Federal Health Care Resilience Taskforce's [ACS toolkit](#) for further guidance on alternative care sites.

COVID-19 has altered the provision of services for people experiencing homelessness and medical respite programs are not exempt. Medical respite programs must consider both an alteration in delivery of health care services and an adaptation in their capacity and/or structure. Medical respite programs have also come into focus as a model for alternative care and isolation sites for persons who test positive for COVID-19. Respite programs must implement safe practices to protect their clients and provide a quality model of care as communities open new sites in response to the increased need. This section outlines steps for existing medical respite programs to safely provide care, as well as for new programs and/or ACS to implement quality and safe accommodations. Additional information can be found in the [Clinical Guidelines for Medical Respite: COVID-19 and Airborne Infectious Diseases \(expected publication August 2022\)](#).

---

<sup>48</sup> CDC. (2020a, April 24). *Considerations for Alternate Care Sites*. Archive of CDC Webpage. Retrieved July 8, 2022, from <https://public4.pagefreezer.com/browse/CDC%20Covid%20Pages/11-05-2022T12:30/https://www.cdc.gov/coronavirus/2019-ncov/hcp/alternative-care-sites.html>

<sup>49</sup> National Health Care for the Homeless Council. (n.d.). *Medical Respite Care*. Retrieved July 8, 2022, from <https://nhchc.org/clinical-practice/medical-respite-care/>

### *Structural Recommendations*

Respite programs are diverse in their structure. Some offer clients single and private rooms as a standard, while others exist within dormitory-style shelter settings. Regardless of setting, programs must modify their structure in order to implement social distancing and isolation guidelines during COVID-19 surges or when COVID-19-positive clients are identified within the respite program. Programs that offer dormitory-style or shared dwellings should ensure that beds are spaced at least 6 feet apart and, if possible, provide structures (e.g., plastic curtains) between beds. If unable to provide individual space for all clients, programs should have isolation rooms available for persons who are demonstrating symptoms, awaiting test results and who have a positive COVID-19 test. As COVID-19-specific resources are removed, programs may consider creating sections or cohorts within their facility to accommodate proper isolation for clients who have tested positive or who are symptomatic and awaiting testing. Programs should ensure that proper sanitation and cleaning is completed throughout the medical respite facility. Some areas may need to be cleaned more frequently, especially those that are communal (such as restrooms).<sup>50</sup>

### *Program and Delivery of Services*

Clients who are isolated for COVID-19 should continue to have access to needed medical services and equipment to support their ability to complete telehealth appointments, as required, with specialty and outside providers. Medical services delivered on-site should be conducted with appropriate PPE for the clients and providers. Programs may choose to implement surveillance screening for COVID-19 of all residents in the medical respite program and should consider COVID-19 testing upon entrance to the program. Clients who are symptomatic, test positive or are awaiting test results should be separated as much as possible within the medical respite program to decrease the risk of person-to-person transmission.

Programs that typically offer group programming (e.g., health education groups, support groups, etc.) should consider alternative ways to disseminate information and provide support to clients during COVID-19 spikes or when a client who is positive for COVID-19 is present in the program. Some programs may be able to offer groups safely if clients and staff are socially distanced throughout and wearing masks. Community areas should be properly sanitized between use, and universal masking and hand sanitizer should be encouraged. Accommodations must also be made for meals to be safely consumed because this is a time when mask-wearing is not possible.

---

<sup>50</sup> CDC. (2021, November 15). *Cleaning and Disinfecting Your Facility*. <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html> (2022b, January 18).

### *Trauma-Informed Environment*

People experiencing homelessness have often experienced significant trauma, which the COVID-19 pandemic and accompanying restrictions and deprivation have exacerbated. It is critically important that both existing and newly developed programs implement trauma-informed care principles in their program and services. Programs should engage with their clients to identify concerns and implement supports in response (e.g., offering additional mental health support services, modifying service delivery, etc.).

### *Patient Support*

Ensure that medical respite clients have information and education regarding the current state of precautions and restrictions within their community. Restrictions within the program may differ from those of the community, and it is important to explain and clarify these differences to assure the safety of all. Clients should also have consistent access to masks, self-care and hygiene supplies, continued education on hygiene and proper masking (which staff and providers can demonstrate), along with staff hanging up laminated visuals within shared spaces. Clients should also be supported in accessing supplies to follow community guidelines, such as being offered face masks, at-home COVID-19 tests, and a space to launder personal items.

Programs should also support clients' ability to stay in isolation and manage subsequent mental health impacts. As much as possible, programs should offer activities that clients can safely engage in while remaining socially distanced and/or isolated, such as activities and supplies for writing, drawing, reading, puzzles, etc. Programs with more funding may opt to provide technological resources (such as on-site Wi-Fi and tablets) for use while at the program.

Similarly, programs must consider the impact of isolation on other health conditions, such as substance use. Programs should attempt to help clients meet their needs in order to increase the likelihood that they will be able to safely remain in isolation. Strategies could include partnerships to provide medications for opioid use disorder, such as suboxone, the ability to leave the respite for a period of time during the day- allowing clients to acquire/use any needed substances, or creating a managed alcohol program (see section below). Respite program staff should engage with their clients to identify meaningful activities that would support safe engagement and connection while under isolation and social distancing.

## Winter Considerations

Colder months of the year require an additional level of planning. The 2020 Point-in-Time count, the last count not to be significantly restricted due to the pandemic, demonstrated a national increase in people who are experiencing homelessness being unsheltered.<sup>51</sup> Some evidence showed that people sleeping outdoors had a lower positivity rate of COVID-19 compared with those in shelters. Though these studies were small and not generalizable, outdoor settings are lower risk for transmitting COVID-19 compared to indoor settings due to air flow and ability to socially distance. Despite this potential protective factor against COVID-19 transmission, outdoor settings pose additional challenges with lower temperatures, such as hypothermia.<sup>52</sup>

Many communities that experience cold weather rely on a network of informal shelters, including churches and recreational centers, to provide additional beds during the high-demand winter months. These organizations often rely on volunteers. During the first two winters of the COVID-19 pandemic, many of these resources were greatly limited or unavailable. In addition, many shelters have not returned to pre-COVID census numbers, and other privately funded shelters have implemented vaccination and/or COVID-19 testing requirements to gain access, thus limiting access for many vulnerable individuals. The combination of fewer shelter options and fewer beds within each setting compounded the crisis. Each community must anticipate that COVID-19 spikes and outbreaks will occur, not just seasonally but particularly in the winter, and must develop plans to compensate for the loss of available shelter beds to prevent unintended consequences. Hypothermia, exacerbation of chronic respiratory illnesses, and overdose deaths are imminent threats to individuals' health when shelter beds are not available in cold weather.

---

<sup>51</sup> HUD Office of Community Planning and Development. (2021, January). *The 2020 Annual Homeless Assessment Report (AHAR) to Congress*. HUD. <https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf>

<sup>52</sup> *Federal Healthcare Resilience Task Force Alternate Care Site Toolkit, Third Edition*. (2020, June). ASPR TRACIE, Department of Health & Human Services. <https://files.asprtracie.hhs.gov/documents/acs-toolkit-ed1-20200330-1022.pdf>

## From the Field: Alternate Care Sites in Santa Clara, Calif.

Valley Health Care for the Homeless Program (VHCHP) serves over 7,000 individuals experiencing homelessness annually. Along with the leadership team, Medical Director Dr. Cheryl Ho advocated for ACS in their community. Seemingly overnight, they moved over 1,500 individuals into a dozen motels. Ho led this effort and explained how they leveraged their electronic health records to risk-stratify by age and chronic illnesses. They prioritized the elderly and those with multiple, chronic, high-risk illnesses. They changed their entire health care delivery model and established teams on-site at the motels.

The VHCHP pharmacy team saw this as a unique opportunity. Pharmacist Lawrence Chang, PharmD, explained that, with the amazing resources of each patient having a safe place to sleep and access to a phone, they were able to do routine telephonic visits. They utilized this time to simplify medication regimens, educate patients on how to fill their own pillboxes and initiate and complete hepatitis C treatments. The pharmacy team supported the over 1,000 patients in ACS across the county.

Witnessing the coordination across the health system and county in the incredible feat of moving over 1,000 individuals off the street and into safe and secure shelter, Ho said, “Something just broke within me. With thousands of people moved indoors overnight, I am refusing to accept that lack of funding is the reason why homelessness persists.”

## Additional Resources: Shelters, Medical Respite Care, Alternate Care Sites and I&Q Facilities

### *Guidance From the National Health Care for the Homeless Council*

- [Webinar: COVID-19 Coffee Chat: The Role of Medical Respite Care in COVID-19 Response](#) (April 2020)
- [COVID-19 & the HCH Community: Medical Respite Care & Alternative Care Sites](#) (May 2020)
- [Reducing Harm for People Using Drugs & Alcohol During the COVID-19 Pandemic: A Guide for ACS Programs](#) (April 2020)
- [COVID & the HCH Community: Needed Policy Responses for a High-Risk Group](#) (March 2020)
- [COVID-19 Client Triage Tool: Atlanta CoC Example](#) (March 2020)
- [Rhode Island Health Screening Tool](#) (May 2020)



### ***Federal Agencies***

- [Help Stop the Spread of COVID-19 by Watching for These Possible Symptoms / Spanish-Language Version](#) (HUD)
- [Cleaning Activities: You Know You're Ready When You Have / Spanish-Language Version](#) (HUD)
- [What to Do in a Shelter When Someone Shows COVID-19 Symptoms / Spanish-Language Version](#) (HUD)
- [Staff Capacity: Considerations for Scaling Up](#) (HUD)
- [COVID-19 Homeless System Response: Winter Planning Resources](#) (HUD, November 2021)
- [Mitigating the Spread: Washington DC Shelter Profile](#) (HUD, August 2020)
- [Homeless System Response: Supporting Individuals Exiting Isolation or Quarantine](#) (HUD, June 2020)
- [COVID-19: Shelter Management During an Infectious Disease Outbreak / Spanish-Language Version](#) (HUD, March 2020)
- [Preventing and Managing the Spread of Infectious Disease within Shelters](#) (HUD, March 2020)
- [Non-Congregate Approaches to Sheltering for COVID-19 Homeless Response](#) (HUD, June 2020)
- [Quarantine and Isolation Calculator](#) (CDC, March 2022)
- [Screening Clients for Respiratory Infection Symptoms at Entry to Homeless Shelters](#) (CDC, June 2020)
- [A Clinical Resource Guide for Community Care Centers During the COVID-19 Pandemic](#) (Veterans Affairs, March 2021)

### ***National Organizations***

- [Guidance on Leasing of Hotels by Governmental Entities for Use as Temporary Shelters for Quarantining of Homeless Persons During the COVID-19 Pandemic](#) (Community Solutions and the NHLHC, April 2020)
- [Hotel-Hospital COVID-19 Response Playbook](#) (American Society for Health Care Engineering and the American Hotel & Lodging Association, April 2020)

### ***Local Programs***

- [COVID-19 Response Report](#) (Chicago Homelessness and Health Response Group for Equity, June 2020)
- [Guidance for Mitigation of COVID-19 in Homeless Shelters: December 2021](#) (Chicago Department of Public Health)
- [Webinar: COVID-19 Coffee Chat: Structuring I/Q Sites for People Experiencing Homelessness: Examples and Guidance from Alameda County's Project Roomkey](#) (NHCHC, May 2020)

- [Planning Tool for Severe Weather/Emergency Sheltering During COVID-19](#) (Seattle and King County, Wash., December 2021)
- [Supporting COVID-19 Positive and/or Symptomatic Guests Within Congregate Shelter](#) (Seattle and King County, Wash., December 2021)
- [Guidance on the Discharge of High-Risk COVID-19 Persons Under Investigation \(PUI\) or Confirmed Cases](#) (Chicago Department of Public Health, March 2020)
- [Operation Comfort: Alameda County Emergency Hotel Shelter Handbook](#) (Alameda County, Calif., April 2020)
- [Guidelines for Establishing Hotel/Motels as Isolation, Quarantine, Respite or Emergency Shelters](#) (Coalition on Homeless and Housing in Ohio, Columbus, Ohio, April 2020)
- [Guidance to Shelter Providers and Other Community Partners in Operating Under COVID-19 Requirements](#) (Monroe County Shelter Bed Task Group, Monroe County, N.Y., April 2020)
- [Shelter Isolation Best Practices A Guide from Housing for Health](#) (Los Angeles County, Calif., January 2022)

# Testing

## Key Recommendations:

- Testing is part of a comprehensive COVID-19 mitigation strategy.
- Testing should be made widely available to people experiencing homelessness.
- Testing and test results should not be a barrier to accessing services or shelter.

Testing for COVID-19 infection is an important strategy for managing potential outbreaks in shelters, congregate settings and encampments. While testing is an important tool for identifying and managing the spread of COVID-19, testing should not be a prerequisite to accessing homeless services, nor should test results be a barrier to accessing shelter. Shelters and other housing programs that receive HUD funding cannot require testing as part of entrance.<sup>53, 54</sup> Sites should follow guidance on isolation strategies for anyone testing positive for COVID-19.

There are two kinds of tests that can detect current infection, nucleic acid amplification tests, also called NAATs or PCR tests, and antigen tests. While PCR tests are generally more accurate, antigen testing yields faster results and may be easier to administer in community settings. Below, Table 2 compares the two test types.

Testing can be understood as falling into two broad categories: diagnostic and screening. Diagnostic testing is used to identify current infection in individuals who are symptomatic or who are asymptomatic but have a known recent exposure to COVID-19. Screening tests are used to identify asymptomatic infection in people with no current symptoms and no known exposures — for example, screening program staff or people who are entering shelter.

---

<sup>53</sup> CDC. (2022f, April 6). *Interim Guidance for SARS-CoV-2 Testing in Homeless Shelters and Encampments*. <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/testing.html>

<sup>54</sup> HUD Office of Community Planning and Development. (2020, September 1). *Waivers and Alternative Requirements for the Emergency Solutions Grants (ESG) Program Under the CARES Act*. HUD. <https://www.hud.gov/sites/dfiles/OCHCO/documents/20-08cpdn.pdf>

Testing should not be used as an indicator of when to end isolation, as tests may remain positive beyond the infectious period.<sup>55</sup> A PCR test may remain positive for several months beyond an active infection. Rather, facilities should follow CDC guidance for ending isolation and quarantine for congregate settings (see below section).

**Table 2: COVID-19 Test Types**

<b>Summary of Differences Between NAAT/PCR Tests and Antigen Tests<sup>56</sup></b>		
	<b>RT-PCR Tests</b>	<b>Antigen Tests</b>
Intended use	Detect current infection	Detect current infection
Analyte detected	Viral RNA	Viral antigens
Specimen type(s)	Nasal swab	Nasal swab
Sensitivity (ability to detect true positives; high sensitivity means a low number of false negatives)	High	Moderate
Specificity (ability to detect true negatives; high specificity means a low number of false positives)	High	High
Test complexity	Varies	Relatively easy to use
Authorized for use at the point of care	Most devices are not, some devices are	Yes
Turnaround time	Ranges from 15 minutes to greater than 2 days	Approximately 15 minutes
<b>Cost/test</b>	Moderate	Low

<sup>55</sup> CDC. (2022f, April 6). *Interim Guidance for SARS-CoV-2 Testing in Homeless Shelters and Encampments*. <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/testing.html><https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/testing.html>

<sup>56</sup> CDC. (2022, April 4) Guidance for Antigen Testing for SARS-CoV-2 for Healthcare Providers Testing Individuals in the Community. <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html>

*Table 3: Testing in Congregate Settings*

Recommendations for Testing in Congregate Settings
<ul style="list-style-type: none"> <li>• <b>Prioritize people experiencing homelessness for COVID-19 testing:</b> Conduct proactive, diagnostic and screening testing at all shelter and encampment sites to better understand the spread of the virus and the resources needed to appropriately isolate/quarantine individuals. When community spread is low or moderate, universal screening at a site may be utilized to assess for cases and transmission.</li> <li>• <b>Maximize legal authority:</b> Public health authorities should assume a leadership role in the community's response and leverage the legal authority granted local and state governments to advance appropriate responses.</li> <li>• <b>Educate stakeholders:</b> Educate public agency staff about homelessness, the local homeless services system and the health care needs of this population.</li> <li>• <b>Set up provider/public information:</b> Establish a call line or website for shelter providers, outreach workers and/or the general public to access information about how to refer clients for testing and where/when testing events will take place.</li> <li>• <b>Formalize partnerships:</b> Communicate regularly with all agencies and providers involved in coordinating the local response to homelessness. Formalize standing daily/weekly calls between partners to share information and thoughtfully plan next steps.</li> <li>• <b>Set up transportation:</b> Establish clear protocols for transportation to/from testing sites and isolation and quarantine sites, and ensure all providers are knowledgeable of this process.</li> <li>• <b>Conduct COVID-19 education:</b> Educate clients and staff about COVID-19 and their risk for contracting the illness, as well as mask use, social distancing, hand-washing and use of hand sanitizer. Communicate clearly with them about testing events. Let them know what will happen after a positive or negative test result (especially if they will be moved to a new location) and gain informed consent to test and deliver services.</li> <li>• <b>Offer vaccinations:</b> COVID-19 vaccinations remain the most effective line of defense against the COVID-19 illness.</li> <li>• <b>Provide comprehensive health services</b> in conjunction with testing.</li> <li>• <b>Ensure safety of clients and staff:</b> Conduct testing outside whenever possible. Ensure sufficient PPE for testing conditions.</li> <li>• <b>Pursue permanent solutions:</b> Whenever possible, move clients into permanent housing once testing activities and I/Q stays are complete, rather than return them to homelessness.</li> <li>• <b>Actively reverse racial inequities:</b> Improve racial and ethnic inequities by targeting testing initiatives to historically marginalized populations. Collect and regularly analyze race/ethnicity data to ensure equity in access to testing and follow-up care. When possible, ensure the demographics of the testing teams reflect those of the population being tested.</li> <li>• <b>Share data:</b> Ensure robust HIPAA-compliant data-sharing between health departments and CoCs to identify positive cases.</li> </ul>
<p>Comprehensive guidance on conducting testing in congregate setting can be found in the <a href="#">Antigen Testing in Congregate Shelters: Process Outline and Implementation Playbook</a>.</p>

Testing both staff and consumers regularly can facilitate isolation of those who are infected, helping decrease transmission in the shelter setting. A Boston shelter's universal testing revealed that the majority of individuals with newly identified infections had no symptoms at the time of diagnosis.<sup>57</sup> This suggests that screening for symptoms is insufficient for mitigating transmission

<sup>57</sup> Baggett, T. P., Keyes, H., Sporn, N., & Gaeta, J. M. (2020). Prevalence of SARS-CoV-2 Infection in Residents of a Large Homeless Shelter in Boston. *JAMA*, 323(21), 2191. <https://doi.org/10.1001/jama.2020.6887>

in the shelter setting. Symptom screening is more effective if also paired with screening tests or universal testing strategies when the testing supplies and staffing are available. Universal screening strategies are often not practical or possible during widespread outbreaks.

The NHCHC published [Strategies for Proactive Universal Testing](#) in July 2020. This brief synthesizes best practices from HCH programs across the country and provides guidance on universal testing.

## Contact Tracing

Contact tracing is part of a comprehensive community COVID-19 plan that involves working with individuals who have been diagnosed with COVID-19 to identify and provide support to others who may have been infected through direct contact with them. This process aims to prevent further transmission of the infection by separating people who have (or may have) COVID-19 from people who do not.

State and local public health entities are responsible for contact tracing, but we encourage organizations that support people experiencing homelessness to include the practice as part of multiorganizational efforts. The CDC defines close contact as being within 6 feet for 15 minutes or more with someone over a 24-hour period, starting from two days before illness onset (or, for asymptomatic patients, two days prior to test specimen collection).<sup>58</sup>

People experiencing homelessness, health care workers and staff in congregate settings all fall into a high-priority group for close contacts to evaluate and monitor.<sup>59</sup> Because many lack access to cellphones and a permanent address, local health agencies should consider partnering with organizations that have established relationships with people experiencing homelessness.

The HCH and social service agencies that have training in trauma-informed care and who already have relationships with the individuals may have a better understanding of where to find people and how to develop a realistic plan for isolating. Asking individuals to isolate or quarantine requires a thoughtful, person-centered approach with the understanding that isolation may cause additional trauma and harm.

We encourage staff to practice harm-reduction approaches to isolation and quarantine. Strategies include allowing people to come and go from isolation and quarantine sites to handle needed business during the day, providing education on how to keep themselves and others safe

---

<sup>58</sup> CDC. (2022c, February 10). *Contact Tracing for COVID-19*. <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/contact-tracing.html>

<sup>59</sup> CDC. (2022, February 28). *Prioritizing Case Investigating and Contact Tracing for COVID-19*. [www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html](https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/prioritization.html)

if choosing to end isolation or quarantine early (e.g. masking) or when leaving the site, or providing information and resources for people who do not feel ready to enter an I&Q site but who may change their mind and/or who want to protect their community to the best of their ability while remaining where they are.

## **Additional Resources: Testing**

### *Guidance From Federal Agencies*

- [Interim Considerations for Health Departments for SARS-CoV-2 Testing in Homeless Shelters and Encampments](#) (CDC, April 2022)
- [Investigating and Responding to COVID-19 Cases at Homeless Service Provider Sites](#) (CDC, February 2022)

### *Guidance From Local Programs*

- [Point-of-Care COVID-19 Testing Checklist for Homeless Service Providers](#) (Seattle and King County, Wash., November 2021)

### *Academic Research*

- [Characteristics of COVID-19 in Homeless Shelters: A Community-Based Surveillance Study](#) (Annals of Internal Medicine, September 2020)
- [COVID-19 Outbreak at a Large Homeless Shelter in Boston: Implications for Universal Testing](#) (medRxiv, April 2020)



# Providing Clinical Care During the COVID-19 Pandemic

## Key Recommendations:

- Due to higher risk of severe disease, people experiencing homelessness should be closely monitored during the course of a COVID-19 infection.
- Specific populations including undocumented immigrants, LGBTQ+ people and people who use drugs face additional barriers and require special consideration in disaster plans.
- Health care provider burnout is pervasive. Systems need to find ways to support front-line staff during the protracted pandemic.

## Caring for People With COVID-19

More than two years of experience treating COVID-19 has led to improved information on the assessment and management of coronavirus disease. We now have vaccines to prevent and limit illness associated with COVID-19, as well as multiple therapeutics to support people who do become infected and may be at risk for more severe disease. People experiencing homelessness are more likely than the general population to experience chronic health conditions and barriers to care and follow-up, making access to appropriate management and therapeutics very important. Clinical care for people experiencing homelessness is also impacted by the settings in which people are living and receiving care — congregate settings, hotels/ACS, medical respite or encampments. These settings can make monitoring and managing COVID-19 more challenging and necessitate innovative approaches, including outreach and telehealth.

Approximately 80% of COVID-19 infections are asymptomatic or mild, with omicron potentially causing a larger proportion of asymptomatic or mild disease compared with previous variants.<sup>60</sup> While vaccination has also limited disease spread and severity, there remain groups at higher risk for severe disease, including unvaccinated individuals, people over the age of 65 and those with immunocompromised status or chronic conditions like cardiovascular disease, diabetes and

---

<sup>60</sup> CDC. (2022f, March 29). *Omicron Variant: What You Need to Know*. <https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html>

pulmonary disease. Additionally, as has been true since the start of the pandemic, some people without known risk factors will go on to develop severe disease.

Below is general information on the treatment of COVID-19 and the therapeutics currently available. The information provided focuses on outpatient treatment and is not intended to replace clinical assessment and judgement.

*Table 4: Illness Severity and Clinical Management*

Illness Severity	Criteria, Treatment and Follow-Up
<b>Asymptomatic or presymptomatic infection</b>	<b>Criteria:</b> Individuals who test positive for SARS-CoV-2 using a virologic test (i.e., a PCR or antigen test) but exhibit no symptoms consistent with COVID-19.
	<b>Treatment:</b> Individuals should isolate and self-monitor for symptom development. Individuals should be educated on when and how to contact their provider if symptoms do develop.
	<b>Follow-up:</b> Follow-up after a positive test may include contact tracing and monitoring for lingering symptoms that may indicate long COVID. Unvaccinated individuals who test positive should be offered COVID-19 vaccination once their isolation and/or symptoms have ended.
<b>Mild illness</b>	<b>Criteria:</b> Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have dyspnea, evidence of viral pneumonia or hypoxemia.
	<b>Treatment:</b> Individuals are appropriate for telehealth assessment, if available, and should be educated on self-monitoring for worsening of symptoms and how to reach out for help if needed.  Consider therapeutics for those at higher risk of severe disease — see Figure 1 and Table 5 below. Treatments must be started early in the disease course.
	<b>Follow-up:</b> Schedule virtual follow-up for ongoing monitoring. Plan for placement in ACS, if available. Offer vaccination, if applicable, once symptoms have resolved. Monitor for lingering symptoms that may indicate long COVID.

<b>Moderate Illness</b>	<p><b>Criteria:</b> Individuals who show evidence of lower respiratory disease/viral pneumonia during clinical assessment or imaging and/or exhibit mild dyspnea but maintain oxygen saturation, or SpO<sub>2</sub>, greater than or equal to 94% on room air. Clinicians should consider SpO<sub>2</sub> within the context of the patient's symptoms and presentation for people with darker complexions, as <a href="#">studies</a> have shown pulse oximetry to be less reliable for those with darker skin.</p> <p>In most adult patients, if dyspnea develops, it does so between illness days four to eight, though it can sometimes develop after day 10.</p> <p><b>Treatment:</b> In-person assessment is preferred over telehealth, though subsequent monitoring may be completed via telehealth. Providers should identify individuals who may be at risk for disease progression for closer monitoring, including individuals age 65 or older, immunocompromised or with underlying chronic disease. These individuals are at risk for rapid decline in pulmonary status and should be educated to seek help with any worsening dyspnea or SpO<sub>2</sub> below 94%.</p> <p>Consider therapeutics for those at higher risk of severe disease — see Figure 1 and Table 5 below. Treatments must be started early in the disease course.</p> <p><b>Follow-up:</b> Schedule for in-person evaluation due to risk of rapid deterioration. Set up monitoring at ACS or respite, if possible. Monitor for lingering symptoms that may indicate long COVID.</p>
<b>Severe Illness</b>	<p><b>Criteria:</b> Individuals who have SpO<sub>2</sub> less than 94% on room air, moderate-to-severe or worsening dyspnea, respiratory frequency greater than 30 breaths/min, or lung infiltrates greater than 50%.</p> <p>The median days to the development of acute respiratory distress syndrome for those who go on to have severe disease is 2.5 days from the onset of dyspnea.</p> <p><b>Treatment:</b> Requires inpatient hospital treatment.</p> <p><b>Follow-up:</b> Coordinate with inpatient team and evaluate potential for medical respite or placement in ACS at hospital discharge. Monitoring for lingering symptoms that may indicate long COVID.</p>

Adapted from the National Institutes of Health's [Coronavirus Disease 2019 \(COVID-19\) Treatment Guidelines](#).

Figure 1: Current Therapeutics, Nonhospitalized Patients With COVID-19 (NIH, February 2022)

Figure 1. Therapeutic Management of Nonhospitalized Adults With COVID-19

PATIENT DISPOSITION	PANEL'S RECOMMENDATIONS
Does Not Require Hospitalization or Supplemental Oxygen	<p>All patients should be offered symptomatic management (AIII).</p> <p>For patients who are at high risk of progressing to severe COVID-19<sup>a</sup> (treatments are listed in order of preference based on efficacy and convenience of use):</p> <ul style="list-style-type: none"> <li>• Ritonavir-boosted nirmatrelvir (Paxlovid)<sup>b,c</sup> (AIIa)</li> <li>• Sotrovimab<sup>d</sup> (AIIa)</li> <li>• Remdesivir<sup>e,g</sup> (BIIa)</li> <li>• Molnupiravir<sup>c,f</sup> (CIIa)</li> </ul> <p>The Panel <b>recommends against</b> the use of <b>dexamethasone</b> or <b>other systemic corticosteroids</b> in the absence of another indication (AIII).<sup>g</sup></p>
Discharged From Hospital Inpatient Setting in Stable Condition and Does Not Require Supplemental Oxygen	The Panel <b>recommends against</b> continuing the use of <b>remdesivir</b> (AIIa), <b>dexamethasone</b> <sup>g</sup> (AIIa), or <b>baricitinib</b> <sup>g</sup> (AIIa) after hospital discharge.
Discharged From Hospital Inpatient Setting and Requires Supplemental Oxygen <i>For those who are stable enough for discharge but who still require oxygen<sup>h</sup></i>	There is insufficient evidence to recommend either for or against the continued use of remdesivir or dexamethasone.
Discharged From ED Despite New or Increasing Need for Supplemental Oxygen <i>When hospital resources are limited, inpatient admission is not possible, and close follow-up is ensured<sup>i</sup></i>	<p>The Panel recommends using <b>dexamethasone</b> 6 mg PO once daily for the duration of supplemental oxygen (dexamethasone use <b>should not</b> exceed 10 days) with careful monitoring for AEs (BIII).</p> <p>Since remdesivir is recommended for patients with similar oxygen needs who are hospitalized,<sup>j</sup> clinicians may consider using it in this setting. Given that remdesivir requires IV infusions for up to 5 consecutive days, there may be logistical constraints to administering remdesivir in the outpatient setting.</p>
<p><b>Rating of Recommendations:</b> A = Strong; B = Moderate; C = Optional  <b>Rating of Evidence:</b> I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion</p>	

<sup>a</sup> For a list of risk factors, see [Underlying Medical Conditions Associated With Higher Risk for Severe COVID-19](#) and the patient prioritization for treatment section below.

<sup>b</sup> Ritonavir-boosted nirmatrelvir has significant drug-drug interactions. Clinicians should carefully review a patient's concomitant medications and evaluate potential drug-drug interactions.

<sup>c</sup> If a patient requires hospitalization after starting treatment, the full treatment course can be completed at the health care provider's discretion.

<sup>d</sup> The B.1.1.529 (omicron) variant of concern is currently the dominant SARS-CoV-2 variant in the U.S. Sotrovimab is the only anti-SARS-CoV-2 monoclonal antibody that is active against the omicron VOC.

<sup>e</sup> Administration of remdesivir requires three consecutive days of IV infusion.

<sup>f</sup> Molnupiravir has a lower efficacy than the other treatment options. Therefore, it should be used only when the other options are not available or feasible.

<sup>g</sup> There is currently a lack of safety and efficacy data on the use of these agents in outpatients with COVID-19; using systemic glucocorticoids in this setting may cause harm.

<sup>h</sup> These individuals should receive oximetry monitoring and close follow-up through telehealth, visiting nurse services or in-person visits.

<sup>i</sup> Provide an advanced level of home care, including supplemental oxygen (whether patients are receiving oxygen for the first time or are increasing their baseline oxygen requirements), pulse oximetry, laboratory monitoring and close follow-up through visiting nurse services, telehealth, or in-person visits.

<sup>j</sup> See [Therapeutic Management of Hospitalized Adults With COVID-19](#).

**Key:** AE = adverse events; ED = emergency department; IV = intravenous; the Panel = the COVID-19 Treatment Guidelines Panel; PO = orally;

*Table 5: Priority Groups for the Use of Anti-COVID-19 Therapeutics, (NIH, February 2022)*

Tier	Risk Group
1	<ul style="list-style-type: none"> <li>Immunocompromised individuals who are not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of their vaccine status; <i>or</i></li> <li>Unvaccinated individuals who are at the highest risk of severe disease (anyone aged 75 or older or anyone aged 65 or older with additional risk factors).</li> </ul>
2	<ul style="list-style-type: none"> <li>Unvaccinated individuals who are at risk of severe disease and who are not included in Tier 1 (anyone aged 65 or older or anyone younger than 65 with clinical risk factors).</li> </ul>
3	<ul style="list-style-type: none"> <li>Vaccinated individuals who are at high risk of severe disease (anyone aged 75 or older or anyone aged 65 or younger with clinical risk factors).</li> <li><b>Note:</b> Vaccinated individuals who have not received a COVID-19 vaccine booster dose are likely to be at higher risk for severe disease; patients who have not received a booster dose and who are within this tier should be prioritized for treatment.</li> </ul>
4	<ul style="list-style-type: none"> <li>Vaccinated individuals who are at risk of severe disease (anyone aged 65 or older or anyone younger than 65 with clinical risk factors).</li> <li><b>Note:</b> Vaccinated individuals who have not received a COVID-19 vaccine booster dose are likely to be at higher risk for severe disease; patients who have not received a booster dose and who are within this tier should be prioritized for treatment.</li> </ul>

## Telehealth

At the beginning of the pandemic, health centers across the country were driven to utilize virtual care. The public health emergency declaration [allows for states](#) to receive the necessary waivers to implement widespread changes to the criteria for telehealth. A variety of modalities and innovations have been leveraged, including telebehavioral health, telemedicine, teledermatology and teledentistry, which can be provided via telephonic sessions (audio-only), text messaging exchanges and video. Many resources have emerged to enhance virtual care for people experiencing homelessness. In 2020, NHCHC completed telehealth case studies from 17 health centers and lessons learned from across the country were compiled.

Key themes included:

- It is possible to engage patients experiencing homelessness in telehealth services.
- Many interviewees warned against the misconception that patients experiencing homelessness are unwilling or unable to engage in virtual care.
- In many cases, transitioning to virtual care resulted in fewer missed appointments and increased engagement in behavioral health care.

Some states have moved to make telehealth a permanent, reimbursable service under current health insurance. However, many have chosen to return to pre-pandemic state laws that limit or prohibit telehealth services.<sup>61</sup> Many states have resisted making audio-only telehealth a permanently reimbursable service despite the disproportionate impact this has on low-income individuals. Access to phones and internet remains limited, making videoconferencing and agencywide adoption of telehealth services difficult to implement. Establishing telehealth services as a permanent reimbursable service will increase access of care for all individuals. The [Telehealth Extension and Evaluation Act](#) would extend some provisions for telehealth beyond the end of the public health emergency.

---

<sup>61</sup> National Conference of State Legislatures. (n.d.). *State Telehealth Policies*. Retrieved July 9, 2022, from <https://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>

## Special Populations

### *Transgender and Nonbinary Individuals*

The pandemic has uniquely affected transgender and nonbinary (TGNB) individuals. TGNB are more likely than the general homeless population to be unsheltered and sleeping outdoors and therefore lack space to isolate from others or recover from illness.<sup>62</sup> The pandemic halted surgeries for many months, resulting in significant delays in gender-affirming care. Moreover, TGNB individuals often lack social support and face significant discrimination and stigma. Each component of these barriers can be highly traumatic for TGNB individuals. Before the pandemic, TGNB adults experienced suicidal ideation at 11 times compared to the general population.<sup>63</sup> Ongoing trauma-informed care for this population is essential through virtual care and outreach efforts. Gender-affirming care must be viewed as lifesaving.

### *Undocumented Immigrants*

Many undocumented and immigrant workers lack the ability to self-isolate or access medical care, which are essential for protecting them from COVID-19. Accessing benefits may jeopardize one's ability to obtain a green card which may discourage individuals from seeking medical care.<sup>64</sup> Undocumented immigrants make up 8.4% of the total food industry workforce and 30% of all agricultural workers.<sup>65</sup> With limited access to a social safety net, undocumented immigrants are uniquely vulnerable to events such as COVID-19 infection and work exploitation. During a time when many social programs have stopped in-person services, undocumented immigrants have less support than usual, creating a vacuum for employers to take advantage of them. When providing support for undocumented immigrants through outreach, telehealth or in-person service, staff should share specific resources about legal resources and protections. See the below resources for undocumented immigrants in many cities and states.

---

<sup>62</sup> National Alliance to End Homelessness. (2020, July). *Transgender Homeless Adults & Unsheltered Homelessness: What the Data Tell Us*. <https://endhomelessness.org/wp-content/uploads/2020/07/Trans-Homelessness-Brief-July-2020.pdf>

<sup>63</sup> Herman, J. L., Brown, T. N., & Haas, A. P. (2019, September). *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. The Williams Institute. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Suicidality-Transgender-Sep-2019.pdf>

<sup>64</sup> U.S. Citizenship and Immigration Services. (2021, March 10). *Public Charge Fact Sheet*. <https://www.uscis.gov/archive/public-charge-fact-sheet>

<sup>65</sup> Svajlenka, N. P. (2020, December 2). *Protecting Undocumented Workers on the Pandemic's Front Lines*. Center for American Progress. <https://www.americanprogress.org/article/protecting-undocumented-workers-pandemics-front-lines-2/>

## From the Field: Fostering Mental Well-Being During a Pandemic in Tennessee

Eboni Winford, Ph.D., is a psychologist and director of research and health equity with Cherokee Health Systems. CHS is a nonprofit that serves more than 70,000 uninsured or underinsured people across 24 rural and urban clinics in 13 Tennessee counties. Winford shared that the pandemic highlighted inequities in our communities. What became most evident to Winford was "digital inequity." Like many health systems, CHS transitioned to telehealth. Winford highlighted the fact that while communities of color were being disproportionately affected by COVID-19, it was often the same populations who lacked access to broadband. "We can't just pretend we don't see those gaps. We've got to find a solution that's ongoing, realistic and acceptable to the population it serves."

Winford emphasized that broadband needs to be a part of any comprehensive health care system and that phones are a lifeline for people. During phone appointments, the patients would share, "I am so glad you called" and "I need to stay connected." She and her team knew that it would take extraordinary outreach, including written letters and setting up computer stations at their health centers, to ensure people could maintain access to their behavioral health teams. As a psychologist, she had many sleepless nights worrying about her patients who lost loved ones and who were struggling with their mental health.

As the director of health equity, Winford described how her organization created space for staff who faced the compounding crises of a global pandemic and the murders of George Floyd, Breonna Taylor and others. CHS acknowledged racism while developing a social justice listserv and creating a shared drive of coping strategies for patients, staff and family members. The mental and emotion well-being of both staff and patients during this unprecedented time was a top priority for Winford and CHS as a whole.



## **From the Field: When the Health Center Is Considered “Home” in San Jose, Calif.**

The Gender Clinic at the Valley Homeless Health Care Program serves transgender, nonbinary and gender-diverse people experiencing homelessness. The clinic provides comprehensive primary care, hormones, mental-emotional care, social work for help with basic needs and referrals for other services. Prior to the pandemic, Dr. Jacqueline Newton reported that the clinic was considered “home” to many of their consumers. She reflected on beautiful celebrations they have shared as staff and consumers in the past, including a beloved Thanksgiving tradition called Trans-giving, where they share a meal and spend quality time together. Gender-diverse populations are often marginalized by their blood relatives, making holidays particularly painful. Knowing these painful histories, the clinic has sought to provide more than just clinical services and has cultivated an inclusive environment where consumers can find a sense of belonging.

Newton shared that the combination of the pandemic and racist violence nationally has led many consumers who are trans and nonbinary people of color to make painful choices about personal safety over their health and have disengaged from care. Gender-affirming surgeries have been delayed indefinitely, which has caused significant harm. Not being able to access lifesaving medication like hormones adds to the list of traumatic events for these consumers. The staff of the Gender Clinic remain hopeful and continue to try to cultivate a sense of community through telehealth. They are looking forward to a time when they can reopen the Recovery Café and break bread again together with their chosen families.

## Staff Burnout

The provision of health care and social services for people experiencing homelessness has always been challenging. Staff witness violence and suffering, and they push against system failures and inequities on a routine basis. The pandemic has added new levels of suffering and also limited modes of connection and support for those who are suffering. Secondary trauma, or vicarious trauma, is associated with witnessing another person experience a traumatic event. Many clinicians and care providers are experiencing increased amounts of secondary trauma as a result of witnessing their clients deal with the “routine” traumas of homelessness being compounded by the pandemic. Research shows that health care workers and first responders have seen an increase in psychiatric symptoms, including post-traumatic stress disorder, depression, anxiety and recent thoughts of suicide or self-harm.<sup>66</sup> A study in October 2021 showed that one in five health care workers have left the field.<sup>67</sup> Organizations struggle to hire for any position and often have positions open for months, impacting access to care, the morale of current staff and the demands on them.

## Additional Resources: Telemedicine

### *Guidance From the National Health Care for the Homeless Council*

- [COVID-19 & the HCH Community: Ensuring Access to Care Through State Medicaid Telehealth Policies](#) (November 2020)
- [Building the Plane While Flying It: Case Studies on COVID-19, Telehealth, and Health Care for the Homeless Centers](#) (August 2020)
- [Building the Plane While Flying It: Health Care for the Homeless, Telehealth and COVID-19, Part II](#) (September 2020)
- [Webinar: COVID-19 Coffee Chat: Using Telehealth Services for Patient Care](#) (May 2020)

### *Guidance From Federal Agencies*

- [Buprenorphine and Telemedicine COVID-19 Guidance](#) (Drug Enforcement Administration. March 2020)
- [COVID-19 Telehealth Program \(Invoices & Reimbursements\)](#) (Federal Communications Commission, June 2022)

---

<sup>66</sup> Hendrickson, R. C., Slevin, R. A., Hoerster, K. D., Chang, B. P., Sano, E., McCall, C. A., Monty, G. R., Thomas, R. G., & Raskind, M. A. (2021). The Impact of the COVID-19 Pandemic on Mental Health, Occupational Functioning, and Professional Retention Among Health Care Workers and First Responders. *Journal of General Internal Medicine*, 37(2), 397–408. <https://doi.org/10.1007/s11606-021-07252-z>

<sup>67</sup> Plescia, M. (2022, February 11). *If 1 in 5 Healthcare Workers Have Quit, Where Have They Gone?* Becker's Hospital Review. <https://www.beckershospitalreview.com/workforce/if-1-in-5-healthcare-workers-have-quit-where-have-they-gone.html>

### *Guidance From National Organizations*

- [Launching a Toolkit for Safety Net Clinics Implementing Telemedicine During the COVID-19 Pandemic](#) (The Commonwealth Fund, October 2020)
- [General Telehealth Resources](#) (National Consortium of Telehealth Resource Centers, March 2021)
- [COVID-19 Telehealth Coverage Policies](#) (Center for Connected Health Policy)
- [COVID-19 Telehealth Resources](#) (Northeast Telehealth Resource Center)
- [Telehealth Resources for COVID-19 Toolkit](#) (Mid-Atlantic Telehealth Resource Center)
- [Telemedicine for Health Equity Toolkit](#) (Center for Care Innovations, October 2020)
- [National Immigration Legal Services Directory](#) (Immigration Advocates Network)
- [State Telehealth Policies](#) (National Conference of State Legislature)

### *Stress and Burnout*

- [Coronavirus Anxiety Workbook](#) (The Wellness Society)
- [Mindfulness in the Time of Crisis](#) (Changing the Conversation podcast, April 2020)
- [Health Worker Burnout — Current Priorities of the U.S. Surgeon General \(hhs.gov\)](#) (US Department of Health and Human Services)

# Substance Use, Harm Reduction and Treatment

Cowritten with Shannon Smith-Bernardin PhD, RN, CNL

## Key Recommendations:

- Ensure broad access to Narcan (Naloxone).
- Integrate harm-reduction principles.
- Increase access to medication-assisted therapies, including buprenorphine (Suboxone), methadone, naltrexone and acamprosate.

Treatment and related interventions to support individuals with symptomatic substance use have been disrupted in various ways during the COVID-19 pandemic. Both formal and informal substance-use treatment efforts have altered operations due to pandemic guidelines and restrictions.<sup>68</sup> These changes include reductions in capacity at service providers (detoxification, treatment or sobering centers for acute intoxication), closure or service reduction for harm-reduction efforts such as naloxone (Narcan, Evzio) distribution or syringe exchange, and changes in peer-support programs (such as Alcoholics Anonymous) to largely virtual-only access. Deaths related to substance use have increased dramatically during the pandemic. Over 107,000 people died in the U.S. related to drug overdose in 2021, an increase of nearly 15% from 2020, which saw a 30% increase from 2019.<sup>69</sup> Deaths related to alcohol use also increased significantly, with 99,017 alcohol-related deaths in the U.S. in 2020, a 25% increase over 2019.<sup>70</sup>

For people who are experiencing both homelessness and a substance-use disorder, access to treatment services, harm-reduction interventions and related health and social care services were already limited prior to the pandemic. The compounding effects of homelessness, substance use and now COVID-19 have disrupted access to basic needs — accessing appropriate shelter; obtaining substances to avoid sickness and prevent withdrawal; securing water, food and basic hygiene services — and can lead to exceptional vulnerability. While risk and

<sup>68</sup> Glick, S. N., Prohaska, S. M., LaKosky, P. A., Juarez, A. M., Corcorran, M. A., & des Jarlais, D. C. (2020). The Impact of COVID-19 on Syringe Services Programs in the United States. *AIDS and Behavior*, 24(9), 2466–2468. <https://doi.org/10.1007/s10461-020-02886-2>

<sup>69</sup> CDC. (2022i, May 11). U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 - But Are Still Up 15% [Press release]. [https://www.cdc.gov/nchs/pressroom/nchs\\_press\\_releases/2022/202205.htm](https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm)

<sup>70</sup> White, A. M., Castle, I. J. P., Powell, P. A., Hingson, R. W., & Koob, G. F. (2022). Alcohol-Related Deaths During the COVID-19 Pandemic. *JAMA*, 327(17), 1704. <https://doi.org/10.1001/jama.2022.4308>

vulnerability have increased for people experiencing homelessness who use substances, the pandemic has also brought about some positive changes, especially related to access to treatment via telehealth and reduced restrictions around prescribing medications for opioid use disorder. Consider the following recommendations to assist communities in providing safe, client-centered care for those with substance use disorders during these challenging times.

## **Risks of Substance Use During COVID-19**

COVID-19 has increased the risk of using substances in multiple ways. As noted above, overdose and substance related deaths increased throughout the U.S. since the pandemic began in 2020. The pandemic has resulted in closures of or changes to recovery and support programs, increased isolation, financial and emotional stress, altered supply chains for drugs — and, as such, impacted the safety of drug supplies — and led to delays in seeking care due to resource scarcity in health settings and fear of contracting COVID-19. For people experiencing homelessness who use substances, risk of overdose has increased substantially since the start of the pandemic. A study in San Francisco found that deaths among people experiencing homelessness doubled in the year starting in March 2020, with the majority of deaths (82%) attributed to overdose.<sup>71</sup>

## **Effects of COVID-19 on Caring for Individuals With Active Substance Use**

The pandemic has necessitated many shifts in service delivery. These shifts have also impacted people who use drugs. Moving people who typically consume sedating drugs and/or alcohol in a communal environment (such as an encampment) into a non-congregate setting (i.e., individual isolation and quarantine or hotel rooms) can present several risks that should be considered. First is a potential disruption in supply, precluding individuals from obtaining drugs from their regular sources. This disruption may increase risk of overdose due to differing strength of the substance obtained or undesired contamination from fentanyl products, for example. This may also lead to physical withdrawal if individuals are unable to obtain typically used substances, which is potentially life-threatening for alcohol and benzodiazepines. In addition, individuals who typically use with others may be at heightened risk for overdose due to using in isolation. It should be noted that the 2020-21 mortality study conducted in San Francisco found a decreased mortality risk among people relocated to hotels compared with the general population of people

---

<sup>71</sup> Cawley, C., Kanzaria, H. K., Zevin, B., Doran, K. M., Kushel, M., & Raven, M. C. (2022). Mortality Among People Experiencing Homelessness in San Francisco During the COVID-19 Pandemic. *JAMA Network Open*, 5(3). <https://doi.org/10.1001/jamanetworkopen.2022.1870>

experiencing homelessness. Considering these challenges and risks, programs can support people experiencing homelessness by both enhancing and augmenting existing services and creating novel interventions. The harmful or fatal risks related to substance use must be weighed against the risk of contracting COVID-19 when creating program guidance.

## Background on Harm Reduction

Over the last few decades, harm reduction has gained prominence in the response to caring for individuals with substance use. Harm reduction is a public health approach that seeks to diminish the potential negative consequences of drug and alcohol use and other risk-carrying behaviors, rather than focusing on abstinence as the primary goal.<sup>72</sup> The Harm Reduction Coalition adds that harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs despite being marginalized by society.<sup>73</sup> Harm reduction may augment abstinence-based services and is delivered without judgement or contingencies. Numerous harm-reduction efforts have been utilized successfully to provide for individual safety and to support individual preferences around use patterns – including cessation – during the COVID-19 response.

## Enhancing Care for Individuals With Active Substance Use During COVID-19

For all our suggestions and interventions, we highly recommend involving the peer community and those with lived experience of substance use from initial brainstorming and planning to implementation and evaluation. For individual-specific support:

- Facilitate access to virtual peer support services, as well as Alcoholics Anonymous and Narcotics Anonymous meetings. Post meeting schedules in public areas, train staff on resources, and inform individuals upon admission of their options.
- Congregate or non-congregate settings may accommodate virtual meetings by providing computer access, iPads, etc., for clients.
- If safe, consider outdoor support meetings with social distancing and masks.
- Depending on risk level in your community, in-person meetings and support can and should continue, with masking and distancing as appropriate.

---

<sup>72</sup> Schlosser, A., & Harris, S. (2020). Care during COVID-19: Drug use, harm reduction, and intimacy during a global pandemic. *The International journal on drug policy*, 83, 102896. <https://doi.org/10.1016/j.drugpo.2020.102896>

<sup>73</sup> National Harm Reduction Coalition. (n.d.). *Principles of Harm Reduction*. Retrieved July 7, 2022, from <https://harmreduction.org/about-us/principles-of-harm-reduction/>

## **From the Field: Harm Reduction and MOUD During a State of Emergency in New York City**

Dr. Jonathan Giftos is the Medical Director of Addiction Medicine & Drug User health at Project Renewal, a nonprofit organization that provides health, housing and jobs to people experiencing homelessness. In this role, Giftos oversees clinical care for people who use drugs and/or struggle with addiction at Project Renewal's Office of Addiction Services and Supports-licensed programs. These efforts include a medically supervised withdrawal/stabilization unit, outpatient and residential treatment programs, and clinical support to Project Renewal's 28 clinics and mobile medical van.

On March 7, 2020, New York declared a state of emergency due to the coronavirus pandemic. During this unprecedented time, Giftos and his team pushed on to do the work they have always done, just with many additional barriers. The goals of supporting harm reduction for people who use drugs, ensuring access to buprenorphine and methadone for people with opioid use disorder and attending to the physical and mental well-being of people who are experiencing homelessness remained the same. The delivery, energy, access and everything else in the world dramatically shifted. As thousands of people experiencing homelessness were moved out of in-shelter congregate settings to hotels, the Project Renewal team adapted to ensure continued access to critical services. They brought peers to the hotel to run harm-reduction groups, provided buprenorphine inductions through virtual visits, and they collaborated with the city and state to facilitate methadone delivery to the hotels to reduce unnecessary travel and exposure to infection. Ultimately, they worked to help people feel connected while being safe and physically distant.

Giftos shared that moving people into hotel rooms led to "near universal gains." Consumers felt safer, substance use stabilized for many, and COVID-19 infection rates remained lower than expected. During the surge in New York City, many Project Renewal staff lost members of their own families and were juggling care for their children home from school. Despite it all, they continued to show up for their patients. Battling challenges on all fronts, Giftos said the goal was quite simple: Project Renewal's dedicated team continued to provide care for some of the city's most marginalized against many barriers and saved many lives in the process.

## Reducing Overdose Risk

Opioids like heroin, oxycodone and fentanyl may cause respiratory depression that can rapidly lead to death by overdose. Naloxone is a lifesaving medication, available to clinicians and laypeople alike, that temporarily reverses the effects of opioid overdose, including respiratory depression.<sup>74</sup> Naloxone is an important tool for preventing overdose, especially if routines are disrupted by COVID-19-related changes.

In addition to continued education regarding safer use practices (e.g., using with a buddy, staggered use, using a test dose, etc.), specific interventions can increase the distribution of naloxone:

- With appropriate precautions to reduce COVID-19 transmission (i.e., masks, distancing), street outreach teams may directly distribute and train community members during standard or targeted outreach.
- Naloxone training, for both community members and staff, can be done virtually if needed to help increase community capacity.
- Post naloxone on each floor and in common spaces at non-congregate settings, such as shelter-in-place and isolation and quarantine sites.
- During intake for all individuals to all non-congregate settings, include a brief description of naloxone, its uses and where it is available throughout the building or how to obtain a personal supply. Emphasize the potential risk from prescribed medications, and the risk that many stimulants (e.g., cocaine, methamphetamine) may be contaminated with fentanyl.
- Staff may be trained in a “train the trainer” curriculum to provide one-on-one training for incoming individuals as interested.

Social solidarity among people who use drugs, or PWUD, is a central component to harm reduction practice, and PWUD often rely on their fellow users to provide lifesaving naloxone in cases of potential overdose. Thus, reducing isolation for users can directly increase safety and reduce overdose risk. Virtual supervised consumption allows a non-using individual to observe and intervene if there are signs of an overdose. To support this practice, establish or connect individuals to the [“Never Use Alone” hotline](#) that allows a PWUD to be on the phone with someone while they use. Establish internal “virtual supervision” at non-congregate settings. Clients may contact program staff via phone to alert the staff they plan to use. The staff can

---

<sup>74</sup> Office of the Surgeon General. (2018, April 5). *U.S. Surgeon General’s Advisory on Naloxone and Opioid Overdose*. <https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-naloxone/index.html>



either remain with the individual on the phone to confirm safety after a few minutes or can call back within two to five minutes, depending on phone access.

## Syringe Exchange and Use Kits

Syringe service programs (SSPs) are essential for decreasing the risk of infections like HIV and hepatitis C.<sup>75</sup> Beyond access to new needles and safer use supplies, these programs serve as a hub of services and connection for a population that is widely marginalized. As access points for treatment and detox, research has shown that people who utilize SSPs are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who do not use SSPs.<sup>76</sup> According to the CDC, SSPs are considered essential public health infrastructure that should continue to operate during the pandemic.<sup>77</sup>

In times of increased risk or a surge in infections and hospitalizations, recommended efforts for syringe exchange programs include:

- Move indoor SSPs to scheduled outdoor or mobile events, including mobile van access at non-congregate and congregate settings.
- Prepackage supply kits — such as syringes, tourniquets, cooking kits and saline — to decrease the length of face-to-face interactions.
- Offer harm-reduction supplies (e.g., syringes, mix kits or use accessories, condoms) 24/7 in common spaces at non-congregate settings, such as in the front lobby.

## SUD Care and Intervention in Shelter and Residential Settings

It is highly recommended to complete a drug and alcohol use screening at intake to ACS for those who are in isolation or quarantine in order to assess support and programming needs. People who use drugs should be made aware of any program regulations around using on-site, being under the influence on-site, leaving and returning to isolation and quarantine sites, and where safer-use and overdose-prevention supplies are available so they can plan accordingly. Programs should consider developing policies that allow people the freedom necessary to avoid

---

<sup>75</sup> Jarlais, D. C. D., Marmor, M., Paone, D., Titus, S., Shi, Q., Perlis, T., Jose, B., & Friedman, S. R. (1996). HIV incidence among injecting drug users in New York City syringe-exchange programmes. *The Lancet*, 348(9033), 987–991. [https://doi.org/10.1016/s0140-6736\(96\)02536-6](https://doi.org/10.1016/s0140-6736(96)02536-6)

<sup>76</sup> Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 19(3), 247–252. [https://doi.org/10.1016/s0740-5472\(00\)00104-5](https://doi.org/10.1016/s0740-5472(00)00104-5)

<sup>77</sup> CDC. (n.d.-d). *Interim Guidance for Syringe Services Programs*. Retrieved July 9, 2022, from <https://public4.pagefreezer.com/browse/CDC%20Covid%20Pages/19-04-2022T12:28/https://www.cdc.gov/coronavirus/2019-ncov/php/syringe-service-programs.html>

withdrawal-related illness while increasing the likelihood they will be able to complete their isolation or quarantine and remain connected with the program.

Withdrawal from alcohol and benzodiazepines can be life-threatening. Offering treatment is part of a comprehensive approach. For those who are unable or unwilling to engage in traditional abstinence treatment, then nontraditional, harm-reduction-based methods may be appropriate to ensure health and safety, including incorporating managed alcohol use principles within current programs.

## Substance Use Treatment

In order to prevent both overdose and withdrawal, programs must increase access to treatment for substance-use disorders. With changes in scope of virtual health, access to treatment is possible without going into a health center. Early in the pandemic, programs that previously provided daily dosing of Suboxone (buprenorphine/naloxone) or methadone had to adjust to keep both staff and consumers safe, often decreasing the frequency of medical appointments, making telehealth appointments available and often offering multiple days of medication for self-management. Some programs have been able to continue these changes, increasing accessibility to people experiencing homelessness.

### *Opioid Use Disorder*

**Buprenorphine.** HCH programs accounted for over one-third of providers who can prescribe buprenorphine and one-third of all patients receiving buprenorphine in 2017, despite serving only 3% of all health center patients.<sup>78</sup> HCH programs disproportionately provide access to Suboxone for health center patients and are on the front lines of the overdose crisis. When comparing treatment modalities for OUD — including non-intensive behavioral health inpatient detox/residential services, intensive behavioral health, naltrexone, methadone and buprenorphine — only treatment with methadone or buprenorphine was associated with a reduced risk of overdose during a three-month and 12-month follow-up.<sup>79</sup> Additional research has demonstrated that methadone and buprenorphine both reduce all-cause mortality by as much as 50% and are associated with positive changes in several other outcomes, including reductions in overdose, resumed use and HIV infections. Decreasing barriers to accessing buprenorphine and methadone is essential to decreasing opioid-related overdose deaths.

---

<sup>78</sup> NHCHC. (2021, December). *Medication-Assisted Treatment (MAT) for Opioid Use Disorder for People Experiencing Homelessness*. <https://nhchc.org/wp-content/uploads/2021/12/MAT-at-HCH-Programs-2020.pdf>

<sup>79</sup> Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Network Open*, 3(2). <https://doi.org/10.1001/jamanetworkopen.2019.20622>

At the start of the pandemic, the Drug Enforcement Administration waived the requirement that an individual must be seen for an in-person appointment with the prescriber to obtain buprenorphine.<sup>80</sup> This allows individuals to be prescribed buprenorphine after consulting with a waived prescriber via telemedicine without having to physically be in a health center. Studies of out-of-office inductions of buprenorphine have demonstrated equivalent outcomes in retention in treatment programs compared to in-office, observed inductions. Home induction buprenorphine programs began as early as 2003,<sup>81</sup> and numerous studies found no adverse effects of out-of-office induction if offered with appropriate patient education and telephone support.<sup>82, 83, 84, 85</sup> Studies conducted during the first year of the pandemic support previous research outcomes and found no significant difference in buprenorphine induction conducted in person versus via telehealth.<sup>86</sup> This adds to existing evidence that both in-office and out-of-office approaches have similar treatment retention outcomes.<sup>87</sup> In February 2022, Congress introduced bipartisan legislation, the Telehealth Extension and Evaluation Act, that would extend some COVID-19-related telehealth waivers, including changes to telehealth prescribing of controlled substances, for two additional years beyond the public health emergency.<sup>88</sup> While this legislation has not been passed at the time of publication, President Joe Biden had signed legislation that included a 151-day extension of those waivers beyond the end of the public health emergency,

---

<sup>80</sup> Prevoznik, T. W. (2020, March 31). *DEA SAMHSA Buprenorphine Telemedicine*. DEA. [https://www.dea diversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)](https://www.dea diversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068))

<sup>81</sup> Alford, D. P., LaBelle, C. T., Richardson, J. M., O'Connell, J. J., Hohl, C. A., Cheng, D. M., & Samet, J. H. (2007). Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting. *Journal of General Internal Medicine*, 22(2), 171–176. <https://doi.org/10.1007/s11606-006-0023-1>

<sup>82</sup> Bhatraju, E. P., Grossman, E., Tofighi, B., McNeely, J., DiRocco, D., Flannery, M., Garment, A., Goldfeld, K., Gourevitch, M. N., & Lee, J. D. (2017). Public sector low threshold office-based buprenorphine treatment: outcomes at year 7. *Addiction Science & Clinical Practice*, 12(1). <https://doi.org/10.1186/s13722-017-0072-2>

<sup>83</sup> Cunningham, C. O., Giovanniello, A., Li, X., Kunins, H. V., Roose, R. J., & Sohler, N. L. (2011). A comparison of buprenorphine induction strategies: Patient-centered home-based inductions versus standard-of-care office-based inductions. *Journal of Substance Abuse Treatment*, 40(4), 349–356. <https://doi.org/10.1016/j.jsat.2010.12.002>

<sup>84</sup> Sohler, N. L., Li, X., Kunins, H. V., Sacajiu, G., Giovanniello, A., Whitley, S., & Cunningham, C. O. (2010). Home-versus office-based buprenorphine inductions for opioid-dependent patients. *Journal of Substance Abuse Treatment*, 38(2), 153–159. <https://doi.org/10.1016/j.jsat.2009.08.001>

<sup>85</sup> D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence. *JAMA*, 313(16), 1636–1644. <https://doi.org/10.1001/jama.2015.3474>

<sup>86</sup> Barsky, B. A., Busch, A. B., Patel, S. Y., Mehrotra, A., & Huskamp, H. A. (2022). Use of Telemedicine for Buprenorphine Inductions in Patients With Commercial Insurance or Medicare Advantage. *JAMA Network Open*, 5(1). <https://doi.org/10.1001/jamanetworkopen.2021.42531>

<sup>87</sup> Sohler, N. L., Li, X., Kunins, H. V., Sacajiu, G., Giovanniello, A., Whitley, S., & Cunningham, C. O. (2010). Home-versus office-based buprenorphine inductions for opioid-dependent patients. *Journal of Substance Abuse Treatment*, 38(2), 153–159. <https://doi.org/10.1016/j.jsat.2009.08.001>

<sup>88</sup> Telehealth Extension and Evaluation Act, S.3593, 117<sup>th</sup> Congress (2022). <https://www.congress.gov/bill/117th-congress/senate-bill/3593>

giving time for additional legislation to pass.<sup>89</sup> Telemedicine has shown to be critical and effective to initiate buprenorphine starts — particularly at short-term COVID-related facilities, including isolation and quarantine, medical respite or shelter-in-place hotels.<sup>90, 91, 92, 93</sup>

Another potential buprenorphine intervention is treatment with a long-acting, depot form of buprenorphine, Sublocade. Because of its long-acting formulation and monthly dosing, Sublocade can provide treatment and overdose protection without the need for frequent dosing and can be helpful for people who have a hard time managing sublingual buprenorphine at home.

The following are recommendations for making medications for opioid use disorder (MOUD), also known as medication-assisted treatment (MAT), more accessible, both in general and in times of increased COVID-19 risk:

- Screen all incoming individuals to congregate and non-congregate settings for opioid use and interest in MOUD.
- Create or involve an addiction telehealth consult service to refer individuals interested in further discussing treatment or harm-reduction efforts.
- Coordinate with local pharmacies for same-day medication delivery.
- Consider partnering with an addiction medicine or addiction nursing fellowship to provide targeted care and evaluation of interventions.

**Methadone.** Methadone can only be dispensed in federally approved opioid treatment programs with strict regulations around the process. Existing federal regulations require most individuals to be seen in-person for daily dosing. A number of changes were permitted at the onset of

---

<sup>89</sup> James, E. L., & Paolillo, C. L. (2022, March 22). *Telehealth Update: A Federal Appropriations Bill, A Positive OIG Report, and Good News from HHS*. Mintz. <https://www.mintz.com/insights-center/viewpoints/2146/2022-03-22-telehealth-update-federal-appropriations-bill-positive>

<sup>90</sup> Davis, C. S., & Samuels, E. A. (2021). Continuing increased access to buprenorphine in the United States via telemedicine after COVID-19. *International Journal of Drug Policy*, 93, 102905. <https://doi.org/10.1016/j.drugpo.2020.102905>

<sup>91</sup> Mehtani, N. J., Ristau, J. T., Snyder, H., Surlyn, C., Eveland, J., Smith-Bernardin, S., & Knight, K. R. (2021). COVID-19: A catalyst for change in telehealth service delivery for opioid use disorder management. *Substance Abuse*, 42(2), 205–212. <https://doi.org/10.1080/08897077.2021.1890676>

<sup>92</sup> Hughto, J. M., Peterson, L., Perry, N. S., Donoyan, A., Mimiaga, M. J., Nelson, K. M., & Pantalone, D. W. (2021). The provision of counseling to patients receiving medications for opioid use disorder: Telehealth innovations and challenges in the age of COVID-19. *Journal of Substance Abuse Treatment*, 120, 108163. <https://doi.org/10.1016/j.jsat.2020.108163>

<sup>93</sup> Alexander, G. C., Tajanlangit, M., Heyward, J., Mansour, O., Qato, D. M., & Stafford, R. S. (2020). Use and Content of Primary Care Office-Based vs Telemedicine Care Visits During the COVID-19 Pandemic in the US. *JAMA Network Open*, 3(10). <https://doi.org/10.1001/jamanetworkopen.2020.21476>

COVID-19 that can directly offer support to individuals experiencing homelessness who are being served in shelter or transitional facilities.

To respond to the impact of the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration issued guidance on March 16, 2020, enabling methadone programs to increase access to 28-day, take-home supplies of methadone for all “stable” patients.<sup>94</sup> Prior to SAMHSA issuing the new guidance, federal rules required two years of methadone enrollment to receive a month’s worth of take-home medication.

Moreover, opioid treatment programs (OTP) may permit a take-home supply of 14 days for less-stable patients if the OTP determines it is safe — something that would normally only be permitted after one year in treatment. Yet current rules prohibit take-homes for patients in short-term or interim treatment. Thus, patients newly initiating treatment during COVID-19 may not be qualified for take-homes and will still need in-person visits.

On March 30, 2020, SAMHSA released additional guidance outlining the process for methadone receipt for OTP patients who are quarantined or isolated due to COVID-19 — either through a surrogate take-home pickup or “doorstep delivery.”

On March 3, 2022, SAMHSA extended the methadone exemptions for one year beyond the end of the COVID-19 public health emergency. States will have to proactively register concurrence for the extension to be applicable to methadone providers in their state.<sup>95</sup>

---

<sup>94</sup> SAMHSA. (2020, March 19). *Opioid Treatment Program (OTP) Guidance*.  
<https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>

<sup>95</sup> SAMHSA. (2022, March 3). *Methadone Take-Home Flexibilities Extension Guidance*.  
<https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/methadone-guidance>

## **From the Field: The Value of Managed Alcohol Programs in San Francisco**

Early in the pandemic, San Francisco instituted shelter-in-place orders, which included numerous admission and discharge alterations to the city shelter-based homeless system. Led by Dr. Devora Keller, Medical Director, and Alice Moughamian, MSN, RN, Program Director, the Medical Respite and Sobering Center needed to decrease their census and stop taking in new admissions. Additionally, all current clients were encouraged to remain inside to safely physically distance. These clients who remained in the respite program were medically complex due to cognitive impairment or multiple comorbidities. Many were waiting for long-term placement.

Additionally, the Medical Respite operates within a harm-reduction model. Prior to the pandemic, clients were able to leave and return throughout the day. Individuals with an alcohol use disorder are typically able to secure and consume alcohol within the community. Shelter-in-place orders directly disrupted individuals from obtaining alcohol, increasing their risk for alcohol withdrawal or decreasing the chance they could safely remain inside and physically distance. To decrease the harms of ceasing alcohol consumption and increase adherence to shelter-in-place, the staff started a managed alcohol program, which provides beverage alcohol on a schedule throughout the day. This involved a paradigm shift, as the staff began to think of alcohol as a medicine; yet, to support program staff, staff could opt out of participating in the MAP. In collaboration with addiction medicine fellows, the center created new protocols for induction and maintenance phases. Monitoring tools were implemented, and alcohol intake was titrated based on patients' symptoms. The patients were incredibly grateful for the stability the MAP provided them. There was a precipitous drop in trips to the emergency department, and the quality of life for clients improved.

Moughamian shared that it was a difficult transition for the staff. The MAP pushed on the limits of harm reduction, and the clinical team engaged the hospital ethics team to assist them in processing a particularly challenging case. Managed alcohol was also implemented for sobering center clients, and at the isolation and quarantine ACS. The stability it afforded the clients, as well as the staff, was greatly appreciated during a time marked with such chaos.

### *Tobacco and Marijuana*

For individuals with active tobacco or marijuana use, complete cessation upon admission to a non-congregate setting (particularly isolation and quarantine) may not be feasible. To enhance adherence to shelter-in-place, considering the following interventions:

- Provide tobacco-cessation medication on-site, available upon admission, with behavioral health follow-up established for continued support.
- Within isolation and quarantine settings, offer tobacco (e.g., two to three cigarettes per break) on a set schedule for individuals during set break times.
- In states with legalized marijuana, support individuals in receiving marijuana from service delivery.

### *Alcohol Use Disorder*

Individuals with severe alcohol use disorder (AUD) are at higher risk of negative health complications related to the COVID-19 infection as well as to isolation and quarantine and disruption of alcohol access. People with a history of chronic alcohol consumption also have an increased risk of contracting bacterial and viral lung infections, including COVID-19.<sup>96</sup> They are at higher risk for death related to complicated withdrawal because of a combination of lack of access to alcohol, isolation, homelessness, poverty and poor health. Health care providers and community support can mitigate risks by screening for high-risk alcohol use or severe AUD and develop a plan to prevent complications from withdrawal.

Strategies include withdrawal management, long-term treatment with medication, recovery support and/or managed alcohol. Developing a comprehensive plan is essential, especially when individuals are in quarantine and isolation. Not having a plan threatens a negative health outcome from withdrawal and decreases a person's ability to remain in isolation, which puts the greater community at risk for the spread of COVID-19.

## **Managed Alcohol Programs**

Managed alcohol programs (MAP) are a harm-reduction strategy meant to decrease harm from severe AUD, especially for people who are unstably housed or experiencing homelessness. Typically, a MAP will dispense measured doses of alcohol to individuals at regular intervals, with a general goal of stabilizing alcohol intake, avoiding alcohol withdrawal and engaging the

---

<sup>96</sup> Testino, G. (2020). Are Patients With Alcohol Use Disorders at Increased Risk for Covid-19 Infection? *Alcohol and Alcoholism*, 55(4), 344–346. <https://doi.org/10.1093/alcalc/agaa037>

individual in care. MAPs are often coupled with, and offered within, shelter, ACS, respite programs, housing programs and, most recently, isolation and quarantine facilities to provide a safer and more inclusive alternative to abstinence-only housing for individuals with severe AUD. MAPs were scarce in the U.S. prior to COVID-19 yet have been utilized specifically during the pandemic to prevent alcohol withdrawal and help individuals adhere to recommended physical distancing, isolation, and quarantine. COVID-19-related MAPs have provided a template for potential expansion of these types of programs.

The following are recommendations for the implementation of MAPs related to COVID-19 management strategies:

- Establish managed alcohol protocols within shelters, residential settings, or isolation and quarantine locations where individuals are required or recommended to stay on-site.
- Offer a full spectrum of treatment services, including on-site initiation and maintenance of medication-assisted therapies (i.e., naltrexone) and direct referrals to detoxification or treatment as available.
- Offer on-site alcohol-withdrawal management as feasible, depending on available staffing, monitoring capabilities and connection to prescribing providers.
- Provide managed alcohol in cases where traditional care models are unavailable, infeasible or not desired by the individual participant.

These recommendations are based on research evaluating existing MAPs in Canada and emerging work examining managed alcohol services set up for pandemic response.<sup>97, 98, 99, 100</sup>

The data are limited, yet they do demonstrate promising practices for the HCH community.

Recommendations for initiating a managed alcohol protocol include:

- Screen all individuals for daily alcohol consumption at admission.

---

<sup>97</sup> Mattison, C. A., Belesiotis, P., & Wilson, M. G. (2019a, February). *Rapid Synthesis: Determining the Features of Managed Alcohol Programs*. McMaster Health Forum. [https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/determining-the-features-of-managed-alcohol-programs.pdf?sfvrsn=3c0554d5\\_3](https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/determining-the-features-of-managed-alcohol-programs.pdf?sfvrsn=3c0554d5_3).

<sup>98</sup> Ristau, J., Mehtani, N., Gomez, S., Nance, M., Keller, D., Surlyn, C., Eveland, J., & Smith-Bernardin, S. (2021). Successful implementation of managed alcohol programs in the San Francisco Bay Area during the COVID-19 crisis. *Substance Abuse*, 42(2), 140–147. <https://doi.org/10.1080/08897077.2021.1892012>

<sup>99</sup> Pauly, B. B., Vallance, K., Wettlaufer, A., Chow, C., Brown, R., Evans, J., Gray, E., Kryswaty, B., Ivsins, A., Schiff, R., & Stockwell, T. (2018). Community managed alcohol programs in Canada: Overview of key dimensions and implementation. *Drug and Alcohol Review*, 37, S132–S139. <https://doi.org/10.1111/dar.12681>

<sup>100</sup> Chow, C., Wettlaufer, A., Zhao, J., Stockwell, T., Pauly, B. B., & Vallance, K. (2017). Counting the cold ones: A comparison of methods measuring total alcohol consumption of managed alcohol program participants. *Drug and Alcohol Review*, 37, S167–S173. <https://doi.org/10.1111/dar.12648>



- Train front-line staff to utilize objective assessment tools for overintoxication (rapid intoxication assessment scale) or withdrawal (Clinical Institute Withdrawal Assessment of Alcohol Scale, revised).<sup>101</sup>
- Provide comprehensive training with opportunity for discussion and feedback for all staff on the purpose of managed alcohol and harm-reduction efforts.
- Create policies related to the distribution of alcohol on-site. Alcohol may be provided to MAP participants by either nonclinical or clinical staffing.
- Ensure medical consultation, such as with a registered nurse or medical provider, is available at all times when alcohol is available.
- Budget additional staffing at 0.5 to 1.0 full-time equivalent during dosing hours (for example, 8 a.m. to 8 p.m.) to manage supply, dispensing, charting and necessary communication. The staffing levels needed will depend on the setting and number of participating individuals.
- Establish policies for purchasing, safe storage and distribution of alcohol. Individual bottles offer safety and convenience (i.e., 50 mL hard liquor, 12-ounce beer). If using multidose bottles, nursing or other clinical staff should pour measured individual doses.
- Barring delays for overintoxication or emergencies, distribute alcohol on schedule, even if the individual is not showing signs of alcohol withdrawal.
- Alcohol dosing may take place via standing protocols or individual prescriptions and should allow some level of choice in alcohol type for each participating individual. Dosing parameters and guidelines may be developed with the input of staff and clinicians familiar with substance use disorders, alcohol withdrawal and harm reduction. Below is an example of protocol-based dosing (from Alameda County, Calif.), implemented by registered nurses after alcohol consumption screening at intake to an isolation and quarantine site:<sup>102</sup>

---

<sup>101</sup> Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of Alcohol Withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). *Addiction*, 84(11), 1353–1357. <https://doi.org/10.1111/j.1360-0443.1989.tb00737.x>

<sup>102</sup> National Sobering Collaborative. (n.d.). *Alcohol Mgmt*. Retrieved July 9, 2022, from <https://nationalsobering.org/alcohol-management/>

*Table 6: Protocol-Based Alcohol Dosing*

Self-Reported Daily Consumption	Max Amount and Frequency	Daily Limit
1-3 standard drinks	1-2 standard drinks every 1 hour	3 drinks/day
4-6 standard drinks	2 standard drinks every 2-4 hours	6 drinks/day
7-10 standard drinks	3 standard drinks every 2-4 hours	10 drinks/day
11-15 standard drinks	3 standard drinks every 2-4 hours	15 drinks/day
16-20 standard drinks	4 standard drinks every 2-4 hours	20 drinks/day
More than 20 standard drinks	Consult provider	

Similar to dosing by protocols, dosing via an individual prescription is flexible and individualized to each person depending on self-reported consumption, staffing, and alcohol available.

### *Examples of individualized dosing*

**Example for individual stating 8-10 alcoholic standard drinks daily upon intake:** *Dispense 1 standard drink equivalent (12 oz beer, 50 mL vodka) every two hours, plus one additional standard drink equivalent as needed, for CIWA-Ar over 10. Not to exceed 10 standard drinks in one 24-hour period.*

**Example for individual stating they consume 16 standard drinks daily upon intake:** *Dispense up to four standard drink equivalents every three hours from 8:30 a.m. until 8:30 p.m.. not to exceed 16 standard drink equivalents.*

For communities interested in establishing a longer-term managed alcohol program in the community or transitioning a COVID-based MAP to a permanent option, evidence is growing that supports benefits of MAP to individuals with co-occurring homelessness and severe alcohol use disorder. See Table 8 for a table that was adapted from the Operational Guidance for Implementation of Managed Alcohol for Vulnerable Populations developed by the research teams at the Canadian Institute for Substance Use Treatment and British Columbia Centre on Substance Use. It reviews two examples of MAPs: a community-led harm-reduction model and a clinician-initiated team-based model. The appendix includes examples of screening tools and clinical documentation.

The Canadian Managed Alcohol Program Study, established in 2013, has contributed much data regarding the short- and longer-term benefits and challenges of managed alcohol. Their studies and additional reviews of the evidence demonstrate:<sup>103</sup>

- Decreased number of beverages of alcohol consumed per day.
- Increased safety and quality of life.
- Lower incidence of alcohol-related harm.
- Fewer police interactions.
- Decreased emergency-department visits and hospital admissions.
- No significant individual or group-level differences in liver-function test.
- Potential cost-savings.

The co-occurrence of homelessness and substance use have presented challenges to individuals and providers during the COVID-19 pandemic, including factors such as increased risk for infection, inability to shelter in place or negative outcomes related to substance use within the changing environment. The efforts described above endeavor to meet individuals where they are and provide targeted, effective and individualized support in order to reduce risk from the ongoing pandemic and engage people in the most appropriate care. As the pandemic and related response continue to evolve and respond to potential surges or variants, responsiveness related to substance use remains key to protecting marginalized communities.

---

<sup>103</sup> Mattison, C. A., Belesiotis, P., & Wilson, M. G. (2019b, February). *Rapid Synthesis: Determining the Features of Managed Alcohol Programs*. McMaster Health Forum. [https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/determining-the-features-of-managed-alcohol-programs.pdf?sfvrsn=3c0554d5\\_3](https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/determining-the-features-of-managed-alcohol-programs.pdf?sfvrsn=3c0554d5_3).

## Additional Resources: Behavioral Health/Harm Reduction

### *Guidance From the National Health Care for the Homeless Council*

- [Webinar: COVID-19 Coffee Chat: Avoiding Civil Detention: Responding to Clients Who Violate Isolation Orders](#) (April 2020)
- [Webinar: COVID-19 Coffee Chat: Supporting Clients' Mental Health During Isolation and Quarantine](#) (April 2020)
- [Reducing Harm for People Using Drugs & Alcohol During the COVID-19 Pandemic: A Guide for ACS Programs](#) (April 2020)

### *Guidance From Federal Agencies*

- [Medication-Assisted Treatment \(MAT\)](#) (SAMHSA, March 2022)

### *Guidance From National Organizations*

- [COVID-19, Stimulant Use, and Harm Reduction](#) (Vital Strategies, May 2020)
- [COVID-19 Policy Recommendations for OUD, Pain, Harm Reduction](#) (American Medical Association, March 2021)
- [Health Department Responses to COVID-19: Webinar: Supporting SSPS and Harm Reduction Programs](#) (NASTAD, March 2020)
- [Operational Guidance for Implementation of Managed Alcohol for Vulnerable Populations](#) (Canadian Managed Alcohol Program Study, University of Victoria Canadian Institute for Substance Use Research, September 2020)
- [Scale Up of Managed Alcohol Programs](#) (Canadian Managed Alcohol Program Study, University of Victoria Canadian Institute for Substance Use Research, June 2020)
- [Safer Drinking Tips During COVID-19](#) (Canadian Managed Alcohol Program Study, University of Victoria Canadian Institute for Substance Use Research, March 2020)

# COVID-19 Vaccination

## Key Recommendations:

- Vaccines are effective and an essential part of ending the COVID-19 pandemic.
- Broad community partnerships are necessary to ensure equitable vaccine access for everyone.
- There remains distrust of the COVID-19 vaccine. A clear communication strategy is necessary to have successful vaccination campaigns.

In December 2020, the first COVID-19 vaccines became available. To date, there are four vaccines that have FDA approval in the U.S. The four vaccines are known by their brand names: Pfizer-BioNTech (called Pfizer), Moderna, Johnson & Johnson-Janssen (called J&J) and Novavax. The Pfizer and Moderna vaccines are preferred by the CDC. The J&J vaccine is only recommended in certain circumstances and the Novavax vaccine was approved in July 2022 and was not yet available to the public at time of this publication.

Currently, there are COVID-19 vaccines available for everyone ages 6 months and older. There are three types of vaccines currently available: [mRNA](#) vaccines (Pfizer and Moderna), [viral vector vaccines](#) (J&J) and [protein-based vaccines](#) (Novavax). This guide will focus on the two preferred vaccines: Pfizer and Moderna. Information for the J&J vaccine can be found on the [CDC website](#). It is still possible for someone to contract COVID-19 if they are fully vaccinated, and these cases are called “breakthrough” infections. The vaccines have proven to have different efficacy against each variant of COVID-19, but they each have some efficacy against all of the current variants. Vaccines are available to everyone in the U.S., though recent funding changes have the potential to limit access for people who are uninsured.

*Table 7: COVID-19 Vaccine Recommendations for individuals who are not immunocompromised (CDC, June 2022)*

6 months through 11 years

Manufacturer	Age Group	Total # of Doses	Primary Doses	# of Booster Doses	Interval between 1 <sup>st</sup> and 2 <sup>nd</sup> Dose	Interval between 2 <sup>nd</sup> and 3 <sup>rd</sup> Dose
Pfizer-BioNTech	6 months to 4 years	3	3	N/A	3-8 weeks	At least 8 weeks
Pfizer-BioNTech	5-11 years	3	2	1	3-8 weeks	At least 5 months
Moderna	6 months to 5 years	2	2	N/A	4-8 weeks	N/A
Moderna	6-11 years	2	2	N/A	4-8 weeks	N/A

Ages 12-17

Manufacturer	Age group	Total # of Doses	Primary Doses	# of Booster Doses	Interval between 1 <sup>st</sup> and 2 <sup>nd</sup> Dose	Interval between 2 <sup>nd</sup> and 3 <sup>rd</sup> Dose
Pfizer-BioNTech	12-17 years	3	2	1	3-8 weeks	At least 5 months
Moderna	12-17 years	2	2	N/A	4-8 weeks	N/A

## 18 years and older

Manufacturer	Age Group	Total # of Doses	Primary Doses	# of Booster Doses	Interval between 1 <sup>st</sup> and 2 <sup>nd</sup> Dose	Interval between 2 <sup>nd</sup> and 3 <sup>rd</sup> Dose	Interval between 3 <sup>rd</sup> and 4 <sup>th</sup> Dose
Pfizer-BioNTech	18-49 years	3	2	1	3-8 weeks	At least 5 months	N/A
Pfizer-BioNTech	50 and older	4	2	2	3-8 weeks	At least 5 months	At least 4 months
Moderna	18-49 years	3	2	1	4-8 weeks	At least 5 months	N/A
Moderna	50 and older	4	2	2	4-8 weeks	At least 5 months	At least 4 months
Novavax	18 and older	2	2	0	3-8 weeks	N/A	N/A

People who are 50 or older, some people 12 or older who are moderately or severely immunocompromised, and people who received two doses of the J&J vaccine are eligible to receive two booster doses. More information and eligibility can be determined on the CDC's [COVID-19 vaccine booster page](#).

The CDC only lists two [contraindications](#) for the mRNA (Pfizer and Moderna) COVID-19 vaccines:

- History of severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or to a component of the COVID-19 vaccine
- History of a known diagnosed allergy to a component of the COVID-19 vaccine

### *Immunocompromised Individuals*

Individuals who are moderately or severely immunocompromised are at increased risk of severe COVID. In addition, their immune response to the COVID-19 vaccines may not be as strong as

people who are not immunocompromised. For this reason, the CDC [recommends](#) a three-dose primary series followed by two booster doses of the mRNA vaccines.

### *Side Effects*

There are several common side effects associated with the COVID-19 vaccines. These side effects occur because the vaccine is designed to help the body develop an immune response to the COVID-19 illness. These side effects may impact a person's ability to do daily activities but should resolve within a few days. These side effects include:

- Pain, redness, and swelling at the site of injection
- Tiredness
- Headache
- Muscle pain
- Chills
- Fever
- Nausea

Side effects may be more severe in subsequent doses of the vaccine.

### *Vaccine Administration and Mixed Dosing*

Vaccine dosage varies by age, and it is important for health centers to follow [the specific guidance from the CDC](#) to ensure that an individual receives the proper dose. In addition, there are situations that may make it necessary or preferred for an individual to receive a booster vaccine that is different from their primary series doses. The CDC [does not recommend](#) that adults mix products for their primary vaccine series, but mixing is permissible for booster doses depending on age. Both Pfizer-BioNTech and Moderna are authorized for everyone 6 months old and older.

### *Building Vaccine Acceptance*

When vaccines first became available, the demand was so high that people often had to wait weeks before being able to get vaccinated. Once vaccine supply increased and the demand tapered off, focus was placed on building vaccine confidence among those who were hesitant to receive the new COVID-19 vaccines. Vaccine skepticism is common in the health care workforce and the general public for a variety of reasons, especially among BIPOC communities. These communities have experienced historic and ongoing racism in health care and have decreased



access due to higher uninsured rates.<sup>104</sup> An FDA-conducted listening session identified six themes of concern among front-line workers and traditionally underrepresented groups:<sup>105</sup>

- Concern about the speed of the process for developing and testing vaccines.
- Distrust of government.
- Distrust of the health care system.
- Concerns that politics and economics will be prioritized over science.
- Fear the vaccine will not work for certain groups.
- Fear based in past experiences with vaccines.

All research highlights the importance of trusted relationships in helping improve the success of vaccination efforts.

Many of the ways to build vaccine acceptance are core principles to service delivery in HCH programs. One essential way to build vaccine confidence is to have trusted messengers go into the community to spend time with people and provide vaccine education without expectation that people will want to be vaccinated. Some examples of trusted messengers are:

- HCH providers.
- Outreach workers, community health workers, peer navigators.
- [Vaccine ambassadors](#).
- Community and faith leaders.
- Staff of shelters, day shelters and meal programs.

As communities have worked to build vaccine acceptance, many best practices have been developed and shared across the country. It is important to consider where vaccines are being offered, who is providing them, when they are available and what resources are being offered to a person who gets vaccinated. These best practices include:

- Town hall information sessions for people to ask questions directly of providers.
- Outreach — going to where people are and engaging in conversations.
- Waiting for the “slow yes” — not forcing a person to get vaccinated but slowly building toward a “yes.”
- Incentives — gift cards, hygiene kits, hotel nights to cope with side effects.

---

<sup>104</sup> Artiga, S., & Kates, J. (2020, December 2). *Addressing Racial Equity in Vaccine Distribution*. KFF. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/addressing-racial-equity-vaccine-distribution/>

<sup>105</sup> Winckler, S. C. (2020). *COVID-19 Vaccine Confidence Project* [Slides]. Reagan-Udall Foundation for the FDA. <https://www.fda.gov/media/143531/download>

### *Vaccine Mandate in Health Centers*

In November 2021, the Centers for Medicare & Medicaid Services (CMS) issued a rule implementing a vaccine mandate for all health care employees. This rule went into full effect in March 2022 and requires that all employees of a CMS-required facility, which includes federally qualified health center and medical respite care facilities, must be fully vaccinated. As of April 2022, “fully vaccinated” includes only the dose in the primary series of the COVID-19 vaccine. However, many states have added an additional requirement that health care workers also receive the recommended booster dose(s). Only staff who are 100% remote working and do not interact with any staff person from the health care facility are exempt from this mandate. In addition to most staff, [this mandate includes](#) all students, trainees, volunteers and contractors of the mandated facility.

Federal law [requires employers to consider exemptions](#) based on religious or medical factors and provide reasonable accommodations if possible. The CDC has provided guidelines for [the contraindications](#) that qualify for a medical exemption from the COVID-19 vaccine.

### *Seasonal Flu Vaccine*

The influenza vaccine changes every year as the influenza virus changes. This means that individuals should receive the influenza vaccine every year to protect themselves from the most current viruses. Children who are 6 months to 9 years old and receiving the flu vaccine for the first time will need two doses the first year they take the vaccine; others need only one dose of the seasonal vaccine. Routine seasonal flu vaccination is recommended for all staff, volunteers, shelter residents and consumers. It is possible for a person to become sick with seasonal flu as well as COVID-19 simultaneously. Research suggests that individuals who are sick with both viruses at the same time are at greater risk of severe outcomes<sup>106</sup>.

### *Pneumococcal Vaccination*

People who have influenza infections are more likely to develop bacterial pneumonia. Symptoms of pneumonia mimic some of the symptoms of the flu — fever and cough — but also include chest pain and shortness of breath. Vaccines are available to help prevent the onset of pneumonia. Most people will only need to be vaccinated for pneumonia once in their lifetime. CDC recommends pneumococcal vaccination for all children younger than 2 and all adults 65 or

---

<sup>106</sup> Swets, M.C., Russel, C.D., Harrison, E.M., Docherty, A.B., Lone, N., Girvan, M., Hardwick, H.E., ISARIC4C Investigators, Visser, L.G., Openshaw, P.J.M., Groeneveld, G.H., Semple, M.G., & Baillie, J.K. (2022). SARS-CoV02 co-infection with influenza viruses, respiratory syncytial virus, or adenoviruses. *The Lancet*, 399(10334). DOI: [https://doi.org/10.1016/S0140-6736\(22\)00383-X](https://doi.org/10.1016/S0140-6736(22)00383-X)

older.<sup>107</sup> In certain situations, adults 18-65 should also get pneumococcal vaccines if they smoke, have diabetes or have chronic heart, lung or liver disease.

Additional Resources: Vaccines

### *Guidance From the National Health Care for the Homeless Council*

- [Webinar: Trust or Trustworthiness: Which Comes First? \(Series\)](#) (April 2021)
- [Webinar: Increasing Access to COVID-19 Vaccines Among Homeless Populations: Successful Partnerships Series](#) (April 2021)
- [Issue Brief: COVID-19 & HCH Community: Consumer Perspectives of the COVID-19 Vaccine](#) (January 2021)
- [Poverty Policy Podcast: Episode 13: Vaccines](#)

### *Guidance From Federal Agencies*

- [Motivational Interviewing for COVID-19 Vaccine Hesitancy](#) (Mental Health Technology Transfer Center Network, June 2021)
- [Equitable Vaccine Implementation: Reaching People Where They Are](#) (CDC, February 2021)
- [External FAQ: CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule](#) (CMS, January 2022)

### *Guidance From National Organizations*

- [Language That Works to Improve Vaccine Acceptance](#) (de Beaumont Foundation, March 2021)
- [Memo to the Field: COVID-19 and Frontline Employees](#) (NHLC and National Alliance to End Homelessness, March 2021)
- [Memo to the Field: COVID-19 and Consumers](#) (NHLC and NAEH, March 2021)

### *Guidance From Local Programs*

- [Benioff Community Health Outreach Worker Model: Considerations for Vaccine Ambassador Programs](#) (HUD)
- [Lessons Learned: Planning & Implementing a Vaccine Strategy For People Experiencing Homelessness](#) (Vaccinate All 58, March, 2021)
- [Conversation Guide: Breakthrough Infections](#) (National Resource Center for Refugees, Immigrants, and Migrants)

---

<sup>107</sup> CDC. (2022c, January 24). *Pneumococcal Vaccination: What Everyone Should Know*. <https://www.cdc.gov/vaccines/vpd/pneumo/public/index.html>

# Participation in Planning Efforts

## Key Recommendations:

- Ongoing pandemic planning for people experiencing homelessness requires a robust community engagement strategy and anticipation of changing conditions related to seasonal surges and/or new variants.
- Communication plans need to be comprehensive and inclusive of varying abilities, languages and technology access.

The COVID 19 response by businesses, schools and government entities can significantly impact the everyday lives of those in extreme poverty. In response to disease transmission and hospitalization increases, fast-food restaurants, community centers, places of worship, laundromats, libraries and other businesses that inadvertently provide shelter, internet services, public restrooms and sources of community have, at times, closed or restricted services. Programs that serve those without housing can creatively collaborate to determine how to continue their essential work and fill gaps created by community response.

### *Collaboration Between Service Providers to Identify Additional Resources and Sites*

Homeless service providers should make plans for periods when infections and hospitalizations increase and potentially limit shelter space, staffing and medical resources. Learning from past surges, community coalitions should identify additional temporary housing and shelter sites that can provide appropriate services, supplies and staffing. Ideally, these additional sites should include:

- Overflow sites to accommodate shelter decompression (to reduce crowding) and higher shelter demands.
- Isolation sites for people who are confirmed to be positive for COVID-19.
- Quarantine sites for people who are waiting to be tested or who know that they were exposed to COVID-19.
- Protective housing for people who are at increased risk for COVID 19.<sup>108</sup>

Housing providers should plan for challenges around staffing shortages during virus surges that may coincide with cold weather and limited shelter and hotel space. Partnerships with local, state and

<sup>108</sup> CDC. (2022d, February 10). *Community-Based COVID-19 Prevention and Response*.

<https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html#coalition>

federal agencies may need to be leveraged to support people experiencing homelessness during times of high virus spread, hospitalizations and limited resources.

Programs that serve people experiencing unsheltered homelessness can help ensure they have access to updated information about COVID-19 and access to services. The following measures support timely communication about risk and services available:

- Stay updated on the local level of transmission of COVID-19.
- Build on existing partnerships with peer navigators who can help communicate with others.
- Communicate clearly with people sleeping outside.
- Use health materials prepared by credible public health sources, such as your local and state public health departments or the CDC.
- Post signs in strategic places (e.g., near hand-washing facilities) providing instruction on hand-washing, use of hand sanitizer, etc.
- Provide educational materials about COVID-19 for non-English speakers, people with low literacy or intellectual disabilities and people who are hearing- or vision-impaired.
- Ensure communication with clients about changes in homeless services policies and/or changes in physical location of services such as food, water, hygiene facilities, regular health care and behavioral health resources.
- Identify and address potential language, cultural and disability barriers associated with communicating COVID-19 information to workers, volunteers and those you serve.<sup>109</sup>

### *Organizational Planning*

The onset of the pandemic found many programs that serve those without housing ill-prepared for such a crisis. Even as they continue to grapple with COVID-19, service providers must prepare for potential future COVID-19 surges and mitigate future pandemics by developing policies and procedures around the prevention and treatment of infectious disease. These policies should:

- Align with the agency mission and address screening, testing, isolation and quarantine, social distancing and personal hygiene for consumers, staff and volunteers. Special consideration should be made for those who are in high-risk categories.
- Accompany these strategies with a system for communicating policies and changes.
- Identify key representatives and champions from each department within the agency to communicate policy and develop information about the virus with their context.
- Develop strategies for communicating with other stakeholders in the community.<sup>110</sup>

<sup>109</sup> CDC. (2022f, February 10). *Interim Guidance on People Experiencing Unsheltered Homelessness*.

<https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html>

<sup>110</sup> Ready. (2021, February 17). *Crisis Communications Plan*. <https://www.ready.gov/crisis-communications-plan>

## *Communication*

As the pandemic has evolved, and best practices and recommendations have changed as more information and resources become available, clear and effective communication is essential. Here are some important considerations when communicating information about COVID-19 to staff and clients of your program:

- Identify platforms for communications such as a hotline, automated text messaging or a website to help disseminate information to those inside and outside your organization.
- Identify and address potential language, cultural and disability barriers associated with communicating COVID-19 information to workers, volunteers and those you serve above.

## *Community-Wide Planning*

COVID-19 has provided a unique opportunity for community members to collaborate around issues like homelessness, domestic violence, substance use and mental illness. Although these struggles are always present in our communities, government-enforced isolation and quarantine have highlighted this suffering for citizens and communities that may not normally be willing or ready to help.

[Whole Community](#) describes the response that communities require to engage these issues within the context of COVID 19. Preparedness is a shared responsibility; it calls for the involvement of everyone — not just the government — in preparedness efforts. Whole Community means involving a variety of people in the development of national preparedness and ensuring their roles and responsibilities are reflected in the content of the materials.

A robust community response to COVID-19 should include:

- Educators.
- Faith communities.
- Leaders from various racial and ethnic groups represented in the community.
- Local and state health departments.
- Homeless service providers and CoC leadership.
- Emergency management.
- Law enforcement.
- Health care providers.
- Housing authorities.
- Local government leadership.
- Other support services like outreach, case management and behavioral health support.

Those who unite to serve and represent those without housing during the COVID 19 crisis will serve as essential advocates for people who are underrepresented and often unheard during times of crisis. This includes communities of color, low-wage workers, and incarcerated or otherwise detained

---

and homeless populations who are at disproportionate risk of being affected both by COVID-19 and the response to its spread.<sup>111</sup>

## **Additional Resources: Communitywide Response to COVID-19**

### *Guidance From the National Health Care for the Homeless Council*

- [Emergency Preparedness Resources](#)
- [The Advo-Kit: Advocacy Tools for the Health Care for the Homeless Community \(NHCHC\)](#)
- [Issue Brief: Needed Actions from Public Health Systems and Emergency Response Systems \(NCHCH, April 2020\)](#)
- [Policy Recommendations to Temper the Impact of the Coronavirus on Communities of Color \(NAACP\)](#)

### *Guidance From Federal Agencies*

- [Homeless System Response: Changes to Coordinated Entry Prioritization to Support and response to COVID-19 \(HUD\)](#)
- [HUD Issues Availability of Regulatory Waivers for CoC, ESG, and HOPWA Programs to Help Prevent the Spread of COVID-19 and Mitigate Economic Impact \(HUD, April 2020\)](#)
- [Emergency Preparedness and Recovery Resources for Health Centers \(HRSA, January 2022\)](#)
- [Emerging Infectious Disease \(CDC\)](#)
- [Abbreviated Pandemic Influenza Plan Template for Primary Care Provider Offices: Guidance From Stakeholders \(CDC\)](#)

### *Academic Research*

- [Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality \(American Journal of Epidemiology, August 2021\)](#)
- [Epidemiology of COVID-19 Among People Experiencing Homelessness: Early Evidence From Boston \(Annals of Family Medicine, COVID-19 Collection, 2020\)](#)
- [Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality \(Research by Dennis Culhane, Dan Treglia, Ken Steif, Randall Kuhn and Thomas Byrne, 2020\)](#)
- [Community-Level COVID-19 Homelessness Planning & Response Dashboard \(Dashboard based on research report\)](#)
- [Homelessness and the Response to Emerging Infectious Disease Outbreaks: Lessons From SARS. \(Journal of Urban Health: Bulletin of the New York Academy of Medicine, 2008\)](#)

---

<sup>111</sup> COHHIO. (2020, April). *Race, Homelessness, and COVID-19: Guidance for Homeless Services Providers*. <https://cohhio.org/wp-content/uploads/2020/04/Racial-Disparities-COVID-19.pdf>

# Conclusion

As the pandemic moves forward and transitions to an endemic disease we must live with, the best practices and innovative ideas that transformed service delivery to people experiencing homelessness should be continued, strengthened and codified into the homelessness response within communities. This manual was designed to serve as a guidebook for communities and is based in the scientific knowledge and best practices at the time it was written. These will evolve over time, and this manual will be updated regularly to reflect those changes.

Central to all our work around COVID-19 is the ongoing primary effort to end homelessness. This work, and our continued response to COVID-19, must reflect the voices, priorities, and needs of people experiencing homelessness and with lived experience of homelessness. We must acknowledge and address the structural and historic factors that continue to promote and result in ongoing inequity and injustice today. COVID-19 laid bare to a wider audience many of the ways that these factors continue to impact communities, families, and individuals, and it is our hope that those revelations and lessons will inform future health care and housing work moving forward.



# Appendix 1: Screening Tools

## *The Alcohol Use Disorders Identification Test (AUDIT)<sup>112</sup>*

<p>Read questions as written. Record answers carefully. Begin the AUDIT by saying, "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks." Place the correct answer number in the box at the right.</p>	
<p><b>1. How often do you have a drink containing alcohol?</b></p> <p>(0) Never (<i>skip to questions 9-10</i>)          (1) Monthly or less          (2) 2 to 4 times a month          (3) 2 to 3 times a week          (4) 4 or more times a week</p> <div style="text-align: right;"><input type="text"/></div>	<p><b>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</b></p> <p>(0) Never          (1) Less than monthly          (2) Monthly          (3) Weekly          (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p><b>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</b></p> <p>(0) 1 or 2          (1) 3 or 4          (2) 5 or 6          (3) 7, 8 or 9          (4) 10 or more</p> <div style="text-align: right;"><input type="text"/></div>	<p><b>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</b></p> <p>(0) Never          (1) Less than monthly          (2) Monthly          (3) Weekly          (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p><b>3. How often do you have six or more drinks on one occasion?</b></p> <p>(0) Never          (1) Less than monthly          (2) Monthly          (3) Weekly          (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div> <p><i>Skip to questions 9 and 10 if total score for questions 2 and 3 = 0</i></p>	<p><b>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</b></p> <p>(0) Never          (1) Less than monthly          (2) Monthly          (3) Weekly          (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>
<p><b>4. How often during the last year have you found that you were not able to stop drinking once you had started?</b></p> <p>(0) Never          (1) Less than monthly          (2) Monthly          (3) Weekly          (4) Daily or almost daily</p> <div style="text-align: right;"><input type="text"/></div>	<p><b>9. Have you or someone else been injured as a result of your drinking?</b></p> <p>(0) No          (2) Yes, but not in the last year          (4) Yes, during the last year</p> <div style="text-align: right;"><input type="text"/></div>

<sup>112</sup> Babor, T. F., Higgins-Bibble, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition*. World Health Organization: Department of Mental Health and Substance Dependence. [https://apps.who.int/iris/bitstream/handle/10665/67205/WHO\\_MSD\\_MSB\\_01.6a-eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a-eng.pdf)

**5. How often during the last year have you failed to do what was normally expected from you because of drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**Interpretation:** Scores of 8 or higher indicate hazardous or harmful use.

**Total score:**

### *Severity of Alcohol Dependence Questionnaire (SADQ)<sup>113</sup>*

Please recall a typical period of heavy drinking in the last six months. When was this? Please select a number (either 0, 1, 2, or 3) to show how often each of the following statements applied to you during this time.

Statements	Almost never	Sometimes	Often	Nearly always
I woke up feeling sweaty.	0	1	2	3
My hands shook first thing in the morning.	0	1	2	3
My whole body shook violently first thing in the morning.	0	1	2	3
I woke up absolutely drenched in sweat.	0	1	2	3
I dreaded waking up in the morning.	0	1	2	3
I was frightened of meeting people first thing in the morning.	0	1	2	3
I felt at the edge of despair when I awoke.	0	1	2	3
I felt very frightened when I awoke.	0	1	2	3
I liked to have a morning drink.	0	1	2	3
I always gulped my first few morning drinks down as quickly as possible.	0	1	2	3
I drank in the morning to get rid of the shakes.	0	1	2	3
I had a very strong craving for drink when I awoke.	0	1	2	3
I drank more than 1/4 bottle of spirits a day (or 4 pints of beer/1 bottles of wine).	0	1	2	3
I drank more than 1/2 bottle of spirits a day (or 8 pints of beer/2 bottles of wine).	0	1	2	3
I drank more than 1 bottle of spirits a day (or 15 pints of beer/3 bottles of wine).	0	1	2	3
I drank more than 2 bottles of spirits a day (or 30 pints of beer/4 bottles of wine).	0	1	2	3

<sup>113</sup> Stockwell, T., Murphy, D., & Hodgson, R. (2010). The Severity of Alcohol Dependence Questionnaire: Its Use, Reliability and Validity. *British Journal of Addiction*, 78(2), 145–155. <https://doi.org/10.1111/j.1360-0443.1983.tb05502.x>

Imagine the following situation: (a) You have been completely off drink for a few weeks. (b) You then drink very heavily for two days. How would you feel the morning after those two days of heavy drinking?

Symptom	No	Slight	Moderate	A lot
I would start to sweat.	0	1	2	3
My hands would shake.	0	1	2	3
My body would shake.	0	1	2	3
I would be craving for a drink.	0	1	2	3

**Total SADQ Score =**

*Interpretation*

Score	8-15	16-30	31-60
Indication	Mild dependence	Moderate dependence	Severe dependence

### Prediction of Alcohol Withdrawal Severity Scale (PAWSS)<sup>114</sup>

Part A: Threshold Criteria — Yes or No, No Points	
	Have you consumed any amount of alcohol (i.e., been drinking) <u>within the last 30 days</u> ? <b>OR</b> Did the patient have a positive (+) blood-alcohol level on admission?
	<b>If the answer to either is YES, proceed to the next set of questions.</b>
Part B: Based on Patient Interview — 1 Point Each	
1.	Have you been recently <u>intoxicated/drun</u> k, within the last 30 days?
2.	Have you <u>ever</u> undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance)
3.	Have you <u>ever</u> experienced any previous episodes of alcohol withdrawal, regardless of severity?
4.	Have you <u>ever</u> experienced blackouts?
5.	Have you <u>ever</u> experienced alcohol withdrawal seizures?
6.	Have you <u>ever</u> experienced delirium tremens, or DTs?
7.	Have you combined alcohol with other “downers,” like benzodiazepines or barbiturates, <u>during the last 90 days</u> ?
8.	Have you combined alcohol with any other substance of abuse <u>during the last 90 days</u> ?
Part C: Based on Clinical Evidence — 1 Point Each	
9.	Was the patient’s blood-alcohol level greater than 200mg/dL? (SI units 43.5 mmol/L)* <b>OR</b> *Have you consumed any alcohol in the past 24 hours?
10.	Is there any evidence of increased autonomic activity? E.g., heart rate greater than 120 bpm, tremor, agitation, sweating, nausea.
<p><b>Interpretation:</b> Maximum score = 10. This instrument is intended as a <i>screening tool</i>. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndrome.</p> <p>A score of 4 or greater suggests <u>high risk</u> for moderate to severe (complicated) AWS; prophylaxis and/or inpatient treatment are indicated.</p>	

Access [the online version](#) of the original (unmodified) PAWSS.

<sup>114</sup> Maldonado, J. R., Sher, Y., Ashouri, J. F., Hills-Evans, K., Swendsen, H., Lolak, S., & Miller, A. C. (2014). The “Prediction of Alcohol Withdrawal Severity Scale” (PAWSS): Systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol*, 48(4), 375–390.  
<https://doi.org/10.1016/j.alcohol.2014.01.004>

## Appendix 2: Staffing Models for Managed Alcohol Programs

Model Type	Community-Led Harm-Reduction Model	Clinician-Initiated Team-Based Model
<b>Primarily run by</b>	Harm-reduction staff and people with lived experience in community organizations with expertise in alcohol harm reduction.	Collaborative team of clinicians (i.e., nurses), mental health or harm reduction staff, and/or PWLE.
<b>Aims</b>	Low barrier to maintain engagement with individuals who face challenges are uncomfortable accessing traditional health services; focus on harm reduction and wellness, PWLE support, self-management and safer-drinking education.	Aimed at engaging individuals who may meet the criteria for AUD but are not able or interested in pharmacotherapy or other approaches to AUD care. Focus is on preventing alcohol-related harms, including those related to survival drinking, alcohol withdrawal; maintaining or reducing use; and harm reduction.
<b>Participants</b>	Ideally suited for those who do not require or are uncomfortable accessing additional health care supports and are at low-to-moderate risk for complicated withdrawal.	Well-suited for those at higher risk of health complications and/or complicated withdrawal, and who are already engaged or require engagement with the health care system to meet their needs.
<b>Frequency of provision</b>	<ul style="list-style-type: none"> <li>• <b>Mobile/off-site:</b> Alcohol is often stored in one central, secured location, with 1-2 times daily provision — either through client pickup (if appropriate) or delivery (to a single or multiple sites).</li> <li>• <b>Noncongregate or congregate, less intense:</b> Provided directly to clients 3-4 times daily during break times.</li> <li>• <b>Noncongregate, more intense:</b> Provided directly to clients in their rooms as often as every 2-3 hours throughout day and evening.</li> </ul>	

<b>Day-to-day oversight</b>	Community organization, housing provider or contracted service provider.	Staff nurse, with harm reduction, housing or community outreach staff.
<b>Settings</b>	<ul style="list-style-type: none"> <li>• On-site program at community organization, supported housing or shelter.</li> <li>• Delivery program for encampments or scattered temporary or permanent sites (e.g., housing, hotels, shelters).</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical, health center, hospital, nursing station or COVID-19 emergency response center.</li> <li>• Supported housing or hotel/motel.</li> </ul>
<b>Staff requirements</b>	<p>Depends on specific setting and capacity. Example for an on-site program:</p> <ul style="list-style-type: none"> <li>• FTE harm reduction manager with additional PWLe/housing support in a community program could support 20-30 members.</li> <li>• PWLE workers or housing staff can provide support and assist with wellness checks. Access to health care providers (nurse, physician, social worker) should be provided, where possible, for clients with medical or health needs who are not already engaged in care.</li> </ul>	<p>Depends on specific setting and capacity. For example:</p> <ul style="list-style-type: none"> <li>• 0.5 FTE nurse (7 days per week), 1.0 FTE harm reduction or community outreach staff (7 days a week), and addiction medicine support (1 half-day per week) could support a caseload of 15-20 people.</li> <li>• Screening, assessment, intake and alcohol management and monitoring plan by registered nurse in consultation with prescriber.</li> <li>• Example caseload would be feasible with client pickup or staff delivery to client (max 3 sites in close proximity).</li> <li>• During initiation, screening and intake may require increased staffing or reduced caseload.</li> </ul>

Adapted from: Operational Guidance for Implementation of Managed Alcohol for Vulnerable Populations.

# Appendix 3: Sample Clinical Assessment Form

Adapted from Vancouver Coastal Health

PATIENT INFORMATION	
Surname:	Given name(s):
Date of birth:	PHN:
MEDICAL HISTORY (INCLUDING MENTAL HEALTH AND SUBSTANCE USE)	
<hr/> <hr/> <hr/> <hr/>	
<p><b>Substance use</b></p> <p>Type:                      Amount:                      Frequency:</p> <hr/> <hr/> <hr/>	
<p><i>Note: Concurrent use of alcohol and other CNS depressants (e.g., benzodiazepines, opioids) is associated with a significantly increased risk of overdose. Where possible, clients should receive a comprehensive assessment of substance use. For individuals with co-occurring substance use or substance use disorders, clinical judgment should be used, with priority given to substances associated with risk of severe withdrawal, and patients educated on the risks of concurrent use.</i></p>	



### TYPICAL ALCOHOL CONSUMPTION

**Number of drinking days in the past 7 days:**

**On a typical day:**

What type do you drink? (circle all that apply) Beer Wine Sherry Spirits Non-beverage

How much (of each type)?

Total daily intake<sup>115</sup>:

### ALCOHOL-RELATED HARMS

**In the past 3 months, patient has experienced:**

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol withdrawal symptoms, including alcohol-related seizures | <input type="checkbox"/> Alcohol-related ER visits   |
| <input type="checkbox"/> Non-beverage alcohol use  | <input type="checkbox"/> Passing out/losing consciousness from alcohol                                     |
| <input type="checkbox"/> Alcohol-related falls or injuries                               | <input type="checkbox"/> Survival drinking strategies (e.g., panhandling, recycling, sharing with friends) |

### ASSESSMENT FOR WITHDRAWAL RISK, AUD AND AUD SEVERITY

**PAWSS Score:**

**Optional:**

AUD diagnosis and severity:

Number of DSM-5 symptoms:

Hazardous or harmful drinking: AUDIT score:

AUD severity; SADQ score:

- ☐ At risk of COVID-19, confirmed or suspected case

**Eligible for managed alcohol:** Yes No

Client's baseline behavior (to be used to assess over-intoxication at time of provision):

Comments:

**Completed by:**

**Signature:**

**Date:**

<sup>115</sup> Use standard drinks calculator: <http://aodtool.cfar.uvic.ca/index-stdtdt.html>

# Appendix 4: Sample Intake Form

Adapted from PHS Community Services Society

Please fill out and send this form to:

**REFERRED BY:**

**DATE:**

CLIENT INFORMATION	
<b>Name:</b> _____	<b>Phone number:</b> _____
<b>Date of birth:</b> _____	<b>PHN:</b> _____
<b>Client or program address (for alcohol delivery):</b> _____ _____	
<b>Comments on housing situation:</b> _____	
EMERGENCY/FAMILY CONTACT INFORMATION	
<b>Name:</b>  <b>Relation:</b>	
<b>Emergency contact address:</b>  <b>Phone number:</b> _____	
DOCTOR/CLINIC	
_____	

# Appendix 5: Sample Clinical Care Record

Adapted from similar Interior Health Authority and Providence Health Care forms

<b>MANAGED ALCOHOL</b> To schedule alcohol delivery for a client, call xxx-xxx-xxxx and fax this completed order to xxx-xxx-xxxx
<b>Date:</b> _____ <b>Time:</b> _____

TYPE	DOSE
Beer	341 ml to 355 ml = 1 can (1 dose)
Wine	142 ml = 1 glass = (1 dose)
Do NOT exceed 18 total doses/24 hours	

**MANAGED ALCOHOL DOSAGE:**

Please select alcohol type(s) and complete dosing instructions (items with check boxes must be selected to be ordered):

Dosing Guide

Please specify **total daily quantities** for provision (staff will not divide daily doses):

- ☐ x cans of beer (1 can = 341 ml to 355 ml = 1 dose)
- ☐ x bottles of wine (One 750 ml bottle = 5.3 doses)

**PROVISION:**

- ☐ Client to self-manage intake with once-daily provision
- ☐ Staff to provide doses q h PRN to a max of doses/24 hrs

**DURATION:**

**MONITORING INSTRUCTIONS:**

**COMMENTS:**

---

Name

Signature

Contact number

# Appendix 6: Sample Client Alcohol Management Plan and Agreement

Adapted from similar Vancouver Coastal Health and Northwest Territories forms

CLIENT INFORMATION		
Name: _____		Phone number: _____
Date of birth: _____		PHN: _____
CLIENT IDENTIFIED GOALS		
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____		
<i>Note: If client indicates reduced drinking, AUD treatment, or withdrawal management as a goal, client should be connected to a clinician who specializes in treating substance use disorders.</i>		
ALCOHOL MANAGEMENT PLAN		
# of standard drinks (1.5 oz vodka, 355 ml can of 5% beer or 5 oz 12% wine)		Total Daily Dose:
Beverage Type: <b>Wine</b>	Dosage:	
Beverage Type: <b>Beer</b>	Dosage:	
Beverage Type: <b>Other</b> ( ) Dosage:		
Sample drinking schedule: I drink _____ every hours		
Frequency of delivery to client (e.g., daily at 9 a.m.): _____		
Plan for if client is in withdrawal or is out of alcohol: _____		
Schedule of routine primary care check-up (e.g., weekly): _____		
<input type="checkbox"/> Safer drinking education provided <input type="checkbox"/> Pharmacotherapy options discussed, where feasible		

**FINANCES (IF APPLICABLE)**

Client contribution:

Money management plan:

**COMMENTS****CLIENT AGREEMENT**

1. I agree to receive managed alcohol, as outlined above. This includes the types and amounts of alcohol and the schedule for when I will receive the alcohol.
2. Before receiving alcohol, the staff will do a wellness check to see if I have symptoms of withdrawal or COVID- 19, or signs of over-intoxication.
3. I understand that I will not receive alcohol if I am over-intoxicated at the time of delivery.
4. I agree to not access other MAPs or seek additional sources of alcohol outside of the MAP. If I have concerns about my dosage, I will discuss with the program provider. I agree not to share my alcohol with others.
5. [COVID-specific requirements regarding physical distancing]
6. [COVID-specific requirements if suspected infection]
7. I can request help from the staff if I need help with food, medications, communication with family, etc.
8. The staff and I will do a regular check-in on my health, my alcohol consumption, and whether we need to adjust the plan.
9. I am aware that when restrictions due to the COVID-19 emergency are lifted, we may need to discuss a transition plan for my alcohol use.

- ☐ It is ok to contact me to discuss future research on managed alcohol.
- ☐ I do not want my administrative records to be used for evaluation purposes.

I have reviewed and agree to all of the commitments outlined in this alcohol management plan.

Staff Name

Signature

Date

**CLIENT DISCHARGE AND NEXT STEPS**

Date: Reason:

Next Steps:

Client Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

*Rapid Alcohol Intoxication Scale for Managed Alcohol Program*

Score of equal to, or greater than, 3: Withhold pour for one hour, then reassess.

CRITERIA	SCORE			
<b>Speech</b>	0: Normal	1: Slurred; slow	2: Mumbling	3: Disjointed; unintelligible
<b>Coordination</b>	0: Regular walking and movements	1: Tripping	2: Unsteady; tottering; staggering	3: Falling; difficulty coming to or maintaining a standing position
<b>Mental signs</b>	0: Focused, appropriate behavior, judgement and emotions			3: Confused; disoriented; mood swings; overly angry and fighting
<b>Level of consciousness</b>	0: Alert; attentive	1: Drowsy; easily aroused	2: Nodding off; losing train of thought	3: Unable to have a conversation; unable to perform any task
<b>Physical signs</b>	0: Normal breathing; pupils reactive			3: Slow breathing*; pupils pinpoint

\*If someone with a score of 3 or higher has a respiratory rate of less than 12 breaths per minute, call emergency health services.